TROISI DENTISTRY

1354 Kempsville Road, Suite 101 Chesapeake, VA 23320 Office (757)548-1611 Fax (757)548-1051

PATIENT REGISTRATION

Patient Name:___________________________ **Last Name:**___________________________ **Middle Initial:** ________

Preferred Name:___________________________ Referred By:______________ Patient is: □ Responsible Party □ Policy Holder

Patient Information:

Address: ____

City, State, Zip: ____

Home Phone: ______________________ Work Phone: ______________________ Cell Phone: ______________________

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date:__________________Social Security #________-______-________ Driver's License #: ______________________

E-mail: ___________________________________ □ I would like to receive email correspondences

Emergency Contact Name:___________________________Contact #: ______________________

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Employer Name:______________________Employer Address: ______________________

Student Status: ○Full Time ○ Part Time

Preferred Dentist:__________________Preferred Hygienist:__________________Preferred Pharmacy: __________________

Responsible Party: (if someone other than the patient)

First Name:___________________________Last Name:___________________________Middle Initial: ________

Address:___________________________________ City, State, Zip: ______________________

Home Phone: ______________________ Work Phone: ______________________ Cell Phone: ______________________

Birth date:__________________Social Security #:________-______-________ Driver's License #: ______________________

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Primary Dental Insurance Information:

Name of Insured:___________________________Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: ___________________________ Carrier ID: ___________________________

Insured Social Security #: ______________________ Insured Birth date: ______________________

Employer:___________________________ Insurance Company: ___________________________

Address:___________________________ City, State, and Zip: ___________________________

Address 2: ___________________________

City, State, Zip: ___________________________

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MEDICAL HISTORY

PATIENT NAME:________________________________ DATE OF BIRTH: ____________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: ____________________

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: ____________________

Have you ever had a serious head or neck injury? Yes No If yes, please explain: ____________________

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: ____________________

Do you take, or have you taken, Phen-Fen or Redux? Yes No____________________

Are you on a special diet? Yes No ____________________

Do you use tobacco? Yes No____________________

Do you use controlled substances? Yes No____________________

Do you need to pre-medicate? Yes No If yes, please explain: ____________________

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other: ____________________

Women:

Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Do you have any sleep disorder (sleep apnea/snoring)? Yes No If yes, do you wear a C PAP or any appliance? Yes No

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AUTHORIZATION TO USE / DISCLOSE PROTECTED HEALTH INFORMATION
HIPAA CONSENT FORM

Patient Name: ______________________ Date of Birth: ______________

Address: ______________________

____

Telephone: ______________________

Other names under which the Patient has been treated: ______________________

I authorize Dr. Troisi and Associates and its employees, agents or associated healthcare practitioners to use or disclose the Patient's protected health information as described below.

1. **Relevant Time Period.** Dr. Troisi and Associates may use or disclose information relating to healthcare provided during my time as an established patient.

2. **Types of Information.** Dr. Troisi and Associates may use or disclose the following type(s) of information:

   ☐ Any information concerning the Patient's healthcare or payment during the relevant time period.

   ☐ Medical records concerning the Patient's healthcare during the relevant time period, including:
   Records from the Patient's chart (*e.g.*, history, examination, progress notes, lab results, diagnostic test results, operative reports, discharge summaries, photographs, *etc.*)
   Diagnostic images, films or other recordings (*e.g.*, x-rays, MRI scans, CT scans, *etc.*)

   ☐ Billing and payment records for healthcare rendered during the relevant time period.

   ☐ Other: ______________________

3. **Persons to Whom Disclosure Allowed.** Dr. Troisi and Associates may disclose the information to the following person(s):

   Name and relation: ______________________

   Address: ______________________

   ____

   Phone number: ______________________

   ☐ **FULL ACCESS to allowed person(s)**

   ☐ **PARTIAL ACCESS to allowed person(s)**

   (Circle which of the following is/are allowed to be disclosed: Financial, Treatment, Health History, Clinical Documents)

4. **Purpose.** Dr. Troisi and Associates may use or disclose the information for the following purpose(s):

   ☐ The disclosure is made at the Patient's request.

   ☐ For a potential or pending legal proceeding.

   ☐ For marketing. Dr. Troisi and Associates will not receive remuneration from a third party for the use or disclosure of the information.

   ☐ Other: ______________________

I understand that I have the right to revoke this authorization at any time except to the extent that PROVIDER has taken action in reliance on this authorization. To revoke this authorization, I must submit a written revocation to: **1354 Kempsville Rd. Suite 101, Chesapeake, VA 23320 or Fax: 757-548-1051**

I understand that Dr. Troisi and Associates may not condition the Patient's healthcare on this authorization unless (1) the purpose for Dr. Troisi and Associates evaluation and treatment is to obtain and disclose information to entities consistent with this authorization, or (2) the Patient is involved in research-related treatment and the use or disclosure is for such research.

I understand that information disclosed by Dr. Troisi and Associates pursuant to this authorization may be re-disclosed by the entity who receives this information and may no longer be protected by privacy regulations.

______________________ ______________________
Signature Date

____
Authority or relationship to the Patient

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NOTICE OF DEEMED CONSENT TO BLOOD TESTING

A Virginia Law was enacted in 1989 that allows Healthcare Providers to test their patients for HIV antibodies when a healthcare worker is exposed to the blood or body fluids of a patient in a way, which may transmit human immunodeficiency virus (HIV), the virus that causes AIDS. Because of this Law, in the event of such an exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the exposed health worker. Except in emergencies, you will be informed before any of your blood is tested for HIV antibodies, the testing will be explained to you and you will be given the opportunity to ask any questions you might have. You will be provided with the test results and appropriate counseling.

Should an employee be exposed to my blood/body fluid in a way that might allow transmission of infection due to blood borne disease (e.g. HIV, Hepatitis etc.) or other communicable diseases; I understand that according to **Virginia State Law** for the safety, health and possible treatment of our employee, samples of my blood or body fluid may be tested for evidence of infection. Test results, if positive are required by law to be reported to the Virginia Department of Health.

I have read and understand the above Notice of Deemed Consent to Blood Testing.

Patient Signature:____Date: ______________

Parent/Guardian Signature:______________________________________Date: ______________
(If patient is under the age of 18)

Employee/Staff Signature:_______________________________________Date: ______________

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INFORMED CONSENT TO PHOTOGRAPH

The Department of Health and Human Services has established a "Privacy Rule." The Privacy Rule was created in order to provide a standard for certain healthcare providers to obtain their patients' consent for uses and disclosures of health information.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. Part of your treatment may include photographs of the face and teeth/smile. We may desire to use the photographs taken of you by our office for treatment, educational, and/or advertising purposes. However, prior to using any photographs for advertising purposes we will obtain consent from the patient, parent, or legal guardian.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

I, ____ , □**do / □ do not** give consent for Dr. Troisi and Associates or staff to take and/or display photograph(s) of the face and teeth/smile of the patient's listed below. The photograph will be used for educational and/or advertising purposes by Troisi and Associates Family Dentistry and may be displayed within our office and/or on the dental office's webpage, www.estradadds.com
The doctors and office and staff will protect the patient's personal data, such as name, age and date of birth, from being displayed.

Additional family members (if applicable):

Patient's Name: ____ D.O.B: ___________________

Patient's Name: ____ D.O.B: ___________________

Patient's Name: ____ D.O.B: ___________________

Printed Name: ____

Signature: ____ **Date**: ______________________

Relation to Patient:

_____Self   ______Guardian

Witness: ____ Date: ______________________

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COVID-19 Pandemic Dental Treatment Consent Form

I, ______________________________ (**OR GUARDIAN IF UNDER THE 18 YEARS OF AGE**), knowingly and willingly consent to have dental treatment by Dr. Troisi during the COVID-19 pandemic. **PLEASE CHECK ALL BOXES THAT APPLY.**

☐ I confirm that **I AM NOT CURRENTLY PRESENTING ANY OF THE FOLLOWING SYMPTOMS OF COVID-19**, and **HAVE NOT** presented the following symptoms **WITHIN THE LAST 10 DAYS:**

- Fever (temperature of 100.4°F (38°C) or higher)
- Shortness of Breath
- Dry Cough or Sore throat
- Congestion or Runny Nose
- Headache or Fatigue
- Muscle or Body Aches
- New Loss of Taste or Smell
- Nausea, Vomiting, or Diarrhea

☐ I verify that **I HAVE NOT BEEN TESTED POSITIVE FOR COVID-19 WITHIN THE LAST 10 DAYS,** and **I HAVE NOT BEEN IN CONTACT WITH ANY PERSON(S) TESTED POSITIVE FOR COVID-19 WITHIN THE LAST 10 DAYS**.

☐ I acknowledge the increased risk of contracting and transmitting the virus during any form of travel, and **I HAVE NOT TRAVELED OUT OF THE STATE WITHIN THE LAST 10 DAYS.**

☐ I verify that I HAVE **FOLLOWED THE CDC'S RECOMMENDATIONS TO SELF-QUARANTINE FOR A PERIOD OF 10 DAYS IF RECENTLY TRAVELED OR INFECTED BY THE VIRUS.**

☐ **I AM NOT WORKING IN A COMMUNITY WHERE COVID-19 IS OCCURRING (HEALTHCARE WORKER).** If you do work in a community with COVID-19, please note where:

____

☐ I am aware that there is a risk of contracting the virus in this or any dental office, given the fact that patients must enter and exit the practice for routine dental care, the characteristics of the virus, and the aerosolized nature of dental procedures, therefore I waive my right to hold Troisi & Troisi, PC liable should I contract COVID-19 following my dental procedure(s).

By signing my name below, I attest that I have answered the above questions truthfully to the best of my knowledge.

____ ______________

Signature of Patient (or guardian if under the age of 18) Date

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FINANCIAL POLICY

Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality care you need or desire. In our office, we strive to maximize your insurance benefits and make any remaining balance easily affordable. Our fees are based on the quality materials we use, and the time, effort, and skill required in performing your needed treatment. We charge what is the usual and customary for our area. We will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help you achieve oral health. Ultimately, however, You are responsible for payment regardless of any insurance companies arbitrary determination of usual and customary rates.

ALL PATIENTS ARE EXPECTED TO PAY IN CASH, CHECK, OR CREDIT CARD THE DAY SERVICE IS RENDERED, UNLESS SPECIFIC ARRANGEMENTS ARE MADE IN ADVANCE. PLEASE CHECK ALL BOXES.

Insurance

☐ For those patients covered by insurance, we will accept assignment of benefits. This means you must sign the portion of your insurance form that assigns payment to our office. Most policies do not cover 100% of the cost of your treatment. Because of this, and the extreme delay in receiving payment from your insurance company, you will be asked to pay your deductible and your portion of the charges the day services are rendered. We will estimate, as closely as possible, your coverage, but until we actually receive the payment from the insurance company, it is just an estimate. Payment from your insurance company is not guaranteed until they process the claim. We will assist you in dealing with your insurance company, but ultimately the responsibility lies with you. If, after 45 days, the insurance company has not paid, the balance will be due, in full, by you.

Missed Appointments

☐ Missed appointments will cause a delay in your treatment. Please contact our office **no less than 48 hours prior** to your scheduled appointment. We try to keep our costs at a minimum; however, patients who do not show up for their reserved appointment will create undue costs to our office (the costs for the staff and their preparation of your treatment). Patients requesting emergency treatment may be seen at this available time. We will charge the normal fee for an office visit **($73.00 per hour)** if you fail to contact our office **48 hours prior** to your treatment. Your cooperation in the matter will be greatly appreciated. If patients are going to be more than 15 minutes late for their scheduled appointment, the office has the right to reschedule patient for another time so that other patients can be seen at their scheduled time.

Deposit/Retainer Fees

☐ Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for reservations over 2 hours, we require a mandatory non-refundable 30% retainer fee at the time any major appointment is scheduled. This fee is applicable for crown, bridge, denture inlay/onlay appointments or any extensive treatment with an appointment time of 2 or more hours.

Return Check Policy/Finance & Service Charges

☐ In the event your check is returned unpaid for insufficient or uncollected funds, we may re-present your check electronically for the face amount of the check plus the posted return check charge ($35.00) and any statutory fees allowed by law. If a payment arrangement is made and the funds are not available, you will receive one courtesy call. If the problem persists there will be a non-sufficient fee charge of $35.00. Any balance left remaining in your account will be subject to a $2.00 service charge, balances over 30 days will be subject to a 1.5% finance charge monthly until balance is paid in full. If there is a balance remaining for more than 90 days, the account will be sent to collection and/or court.

If you have any questions, please feel free to ask your insurance company or us at any time. We wish to be of assistance in any way we can.

I HAVE READ AND THOROUGHLY UNDERSTAND DR. TROISI OFFICE FINANCIAL AND CANCELLATION POLICY.

____ ____________________

Printed Name OF PATIENT OR GUARDIAN — Patient's Signature or Parent/Guardian if patient is a minor — Date

____ ____________________

Witness Signature — Date