BrickellPeriodontics
PERIODONTAL MEDICINE • ORAL PLASTIC SURGERY • DENTAL IMPLANTS
Irene Marron-Tarrazzi, D.M.D., M.S.

Patient Registration

Name: _____

Date of Birth: _____ Marital Status: _____

Home Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Name of Dentist: _____ How Long: _____

Name of Physician: _____ How Long: _____

Whom may we thank for referring you to our office? _____

Whom may we contact in case of an emergency?_____

Occupation: _____ Employer: _____

Driver's License #:_____ Social Security #:_____

Preferred Pharmacy: _____

Primary Insurance Information

Insurance Company: _____

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Social Security #: _____ Policy Owner's Date of Birth: _____

Employer: _____ Employer ID #: _____

HIPAA Authorization- Authorization for Release of Identification Health Information

We are required by law to make sure that health information that identifies you is kept confidential. We may use and disclose health information about you for appointments, treatments, payments, insurance, response to lawsuits, for law enforcement, coroners medical records and funeral directors. You have the right to request restrictions and the disclosure of your health information.

I give my specific authorization for these records to be release. Your records are only available to you, unless we have your written authorization to release your personal protected information to a designee.

I authorize to have access to my personal protected information the following:

❑**Dentist/Specialist** ❑**Insurance** ❑**Other:** _____ **Signature**: _____

Acknowledgement of Receipt

I acknowledge that I received a copy of the Notice of Privacy Practices from Dr. Irene Marron-Tarrazzi.

Patient's Name:_____**Date:**_____

Signature_____

If you are signing as a representative of the patient, describe your relationship to the patient and sign this form:

Print Name: _____**Relationship to Patient**:_____

Signature:_____**Date:** _____

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Office Financial Policies and Payment Options

We are pleased to welcome you to our office. New patients are always appreciated. Our Practice is growing because of its excellent relationship with our referring doctors and patients.
As our patient, feel free, at any time, to express concerns or to ask any questions that you may have for Dr. Irene Marron-Tarrazzi or our staff. In order to assist you in making payments for your treatment, the following options are listed. Please read them carefully and feel free to discuss them with us.
Payments – You may make any payment using cash, checks, Master Card, Visa, American Express and Discover credit cards.

Uninsured Patients – If you do not have insurance, payment is due in full at the time treatment is provided. **Initials:** _____

Insured Patients – If you have dental insurance, we will submit your dental claim to your insurance carrier for you. You will be asked to present a current insurance card. You are responsible, at the time of the appointment, for any deductible and/or patient portion not covered by your dental insurance. If the exact amount covered by insurance cannot be determined at the time of your appointment, we request that you pay the deductible of your treatment. Any remaining balance not covered by your insurance company will be billed to the responsible person and/or policy holder of the account at the discretion of Dr. Irene Marron-Tarrazzi. **Initials:** _____

Important Information for Insured Patients – The amount of coverage paid by your dental insurance company may be based on your dental insurance company's own reduced fee schedule for treatment **and may be less than the actual charges resulting in lower coverage for you.** We have no control over this situation. Lower payment is a direct result of the plan selected by your employer. Please be advised that we cannot waive patient portion payment. We are required by law to collect your patient portion.
Initials: _____

Overdue Balances - All overdue balances are subject to a service charge not to exceed 3% per month. Dental insurance companies are required by law to reimburse this office within 30 days of being billed. Delayed payments may result in your being required to pay the covered portion. We urge you to insist that your dental insurance company make payments in a timely manner.
Initials: _____

Cancellations – ***For cleaning appointments/scaling and root planning***: There is $40.00 cancellation fee after the second time you have rescheduled your appointment without proper cancellation notice.
For surgical appointments: There is $50.00 cancellation fee after the second time you have rescheduled your appointment without proper cancellation notice. **Initials:** _____

I have read and understand these office policies

Print Name: _____**Relationship to patient:** _____

Signature: _____

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MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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 _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

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

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____