# David T. Pascia D.M.D.
# Kelly Kidwell D.M.D.

Welcome to our practice!
In maintaining our philosophy of excellence in dentistry it is important that you provide us with an accurate dental and medical history. Thank you for your cooperation.

NAME: _____ BIRTHDATE: _____/_____/_____
ADDRESS: _____ APT: _____
CITY: _____ STATE_____ ZIPCODE: _____
HOME PHONE: _____ CELL PHONE: _____
E-MAIL ADDRESS: _____ MARITAL STATUS: _____
SOCIAL SECURITY #: _____ DRIVERS LICENCSE: _____

OCCUPATION: _____
EMPLOYER: _____ BUSINESS TELEPHONE: _____
BUSINESS ADDRESS: _____
SPOUSE'S EMPLOYER: _____ BUSINESS TELEPHONE: _____

EMERGENCY CONTACT NAME: _____ # _____ RELATIONSHIP: _____
EMERGENCY CONTACT NAME: _____ # _____ RELATIONSHIP: _____

WHOM MAY WE THANK FOR REFERRING YOU: Patient Name:_____
(or) Sign _____ Online _____ Other: _____
DO YOU HAVE DENTAL INSURANCE? YES ☐ NO ☐

## HEALTH HISTORY

ARE YOU UNDER THE CARE OF A MEDICAL DOCTOR AT PRESENT? ---------- YES☐ NO☐
PHYSICIAN'S NAME: _____ PHONE _____
ARE YOU TAKING ANY MEDICATIONS, DRUGS, AND/OR PILLS? LIST INDIVIDUALLY NAME AND USE
IF YOU HAVE A LIST – PLEASE LET US SCAN THAT INTO YOUR CHART

Name: _____ Reason Taken: _____ Dosage: _____ Frequency: _____
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Name: _____ Reason Taken: _____ Dosage: _____ Frequency: _____
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ARE YOU ALLERGIC TO ANY MEDICATIONS? .....YES ☐ NO ☐
☐ PENICILLIN ☐ ASPIRIN ☐ CODEINE ☐ ERYTHROMYCIN ☐ LATEX
ARE YOU AWARE OF BEING ALLERGIC TO ANY OTHER MEDICATION OR SUBSTANCE (IE LATEX)? ..... YES ☐ NO ☐
_____
WOMEN: ARE YOU PREGNANT? IF YES, TODAYS DATE & HOW MANY MONTHS ARE YOU? _____YES ☐ NO☐

**PLEASE CHECK ANY OF THE FOLLOWING WHICH YOU HAVE NOW OR HAVE HAD IN THE PAST:**

- ☐ ANEMIA/BLOOD DISORDER
- ☐ HIGH BLOOD PRESSURE
- ☐ HIP REPLACEMENT: **WHEN** _____
- ☐ KNEE REPLACEMENT: **WHEN** _____
- ☐ HEART DISEASE
- ☐ HEART ATTACK
- ☐ HEART PACE MAKER
- ☐ ARTIFICIAL HEART VALVES
- ☐ JOINT REPLACEMENT: **WHEN** _____
- ☐ MITRAL VALVE PROLAPSE
- ☐ HAS YOUR MEDICAL DOCTOR EVER SAID YOU HAVE CANCER OR A TUMOR?
  TYPE: _____ DIAGNOSED _____
- ☐ ARE YOU CURRENTLY UNDERGOING CHEMO?
- ☐ DIABETES
- ☐ EPILEPSY OR DIZZY SPELLS
- ☐ COLD SORES/ FEVER BLISTERS
- ☐ RHEUMATIC FEVER
- ☐ HEPATITIS A (INFECTIOUS)
- ☐ BLOOD TRANFUSIONS
- ☐ HEPATITIS B (SERUM)
- ☐ HEPATITIS C
- ☐ HIV POSITIVE/AIDS RELATED SYMPTOMS?
- ☐ ARE YOU CURRENTLY TAKING ANY MEDICATION FOR OSTEOPOROSIS? HOW LONG? _____
  IF NOT, HAVE YOU TAKEN IT IN THE PAST? _____
- ☐ ARE YOU CURRENTLY TAKING STEROIDS FOR ANY HEALTH REASONS? _____

ARE YOU CURRENTLY TAKING BLOOD THINNERS: ☐ YES ☐ NO

HAVE YOU EVER BEEN TOLD YOU NEED TO PRE-MEDICATE WITH ANTIBIOTICS PRIOR TO DENTAL APPOINTMENTS? Yes ☐ No ☐

**IS THERE ANY INFORMATION CONCERNING YOUR HEALTH IN WHICH WE NEED TO BE AWARE OF?....** YES ☐ NO ☐

IF YES, PLEASE EXPLAIN: _____

_____

_____

_____

_____

## DENTAL HISTORY

ARE YOU HAPPY WITH YOUR SMILE? _____ IF NOT, WHY? _____

DO YOU FIND YOURSELF CLENCHING YOUR TEETH? _____ARE YOU INTERESTED IN TEETH WHITENING? _____

DO YOU SMOKE: ☐ YES ☐NO - CHEW TOBACCO: ☐ YES ☐ NO - DO YOU DRINK SODA: ☐ YES ☐ OCCASIONALLY ☐ NO

DATE OF LAST DENTAL HYGIENE VISIT? _____ ARE YOU HAVING PAIN AT THIS TIME? _____

HAVE YOU HAD YOUR WISDOM TEETH EXTRACTED? ☐ YES ☐ NO ☐ UNSURE *IF YES, WHEN (YEAR): _____

HAVE YOU EVER HAD A BAD EXPERIENCE IN A DENTAL OFFICE? _____

*Pascia Dentistry offers Botox and Dermal Fillers – We can schedule a complimentary consultation for you to acquire more information.
Are you interested in a complimentary consultation? Yes, I am interested! ☐ No, not interested ☐

**TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT IT IS MY RESPONSIBILITY FOR DENTAL SERVICES PROVIDED AND IS DUE AND PAYABLE WHEN RENDERED.**

PATIENT NAME PRINTED : _____

PATIENT SIGNATURE: _____ DATE: _____

# David T. Pascia, D.M.D.
# Kelly Kidwell, D.M.D.

## Office Policy

**We reserve time for each patient in our practice.**
**Therefore, our Office Policy is very firm.**

***We value the time of our patients, and thank you in advance for valuing our time as well.***

- **Please arrive promptly for all scheduled appointments.**
- **Lateness of more than 20 minutes will necessitate a rescheduling of the appointment.**
- **All cancellations and rescheduling of appointments require a 48 hour notice.**

**Should you cancel an appointment with less than 48 hours notice it will constitute a broken appointment and a fee of $50 will be assessed.**

I, _____, understand that if I fail to keep my scheduled, confirmed appointments,
Patient Name Printed
a fee of $50 will be assessed to my account and I may be denied further appointments.

**Please review each statement below:**

- A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you change your appointment, we require at least 48 hour notice to avoid a **$50 cancellation fee** (Emergencies are an exception).

- If you do not show for your confirmed appointment a **$50 fee** will be assessed to your account.

- If you fail to keep your scheduled, confirmed appointments and/or continue to cancel any confirmed appointments without proper 48 hour notification, you may be denied further appointments.

- If you are **20 minutes or later** to a confirmed, scheduled appointment we will need to reschedule this appointment. Please note that each appointment is scheduled just for you.

- **We require a firm confirmation for all appointments.** You will receive an email and/or text message one week prior to your scheduled appointment. You can confirm your appointment by calling the office or through text/email. It is the patient's responsibility to confirm their scheduled appointment by phone call, email, and/or text message in order to keep their appointment.
  If we do not receive a **firm confirmation** for your appointment we will take you off the schedule.

**I fully understand & agree with the above conditions.**

Print name: _____ Date: _____

Patient/Parent Signature: _____

2143 49TH St. North – St. Petersburg, FL 33710
(727)321-1900 – www.PasciaDentistry.com
"We Cater to Dental Cowards"

# David T. Pascia, D.M.D.
# Kelly Kidwell, D.M.D.

## HIPAA COMPLIANCE & GENERAL CONSENT FORM

HIPAA PRIVACY RIGHTS

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the ***Health Insurance Portability and Accountability Act of 1996 (HIPAA)***. I understand that by signing this consent, I authorize Drs. Pascia & Pascia ("you") to use and disclose my protected health information to carry out:

* Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
* Obtaining payment from third party payers (e.g., my insurance company); and
* The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of, your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However; if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Dental Information: Please list any individuals we can share your dental information with other than healthcare providers. Dental Information includes but is not limited to: Dental Appointments, Dental Treatment Needed, Dental Treatment Completed, etc.

List names below:

Name Printed (**Not yourself**): _____ Relationship: _____

Name Printed (**Not yourself**): _____ Relationship: _____

☐ I do not want to share my dental information with anyone else.

## CONSENT FOR TREATMENT

I hereby authorize Dr. David T. Pascia, Dr. James T. Pascia, Dr. Kelly Kidwell and their associates, employees, staff, and agents to take x-rays, study models, photographs and/or any other diagnostic aids deemed necessary by the treating dentist to make thorough diagnosis of me or my dependent's dental needs.

Upon such diagnosis, I authorize Dr. David T. Pascia, Dr. James T. Pascia, and Dr. Kelly Kidwell to perform all recommended treatment agreed upon by me, and to give such assistance as required to provide proper care.

**I understand that I may ask for a full explanation of any possible complications.**

Additionally, I authorize the office of Pascia & Pascia Dentistry to contact me at all telephone numbers and addresses provided by me and updated by me, or available through public records.

_____ _____

Patient Name Printed Date

_____

Patient Signature

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## FINANCIAL POLICY

At **Pascia Dentistry,** we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients.

Read below to fully understand Pascia Dentistry's financial policy. Payment is due at time services are rendered. Thank you for allowing us to provide you with a great dental experience in a warm and friendly dental environment.

## ALL PATIENTS - PAYMENT INFORMATION

■ **Pascia Dentistry does require payment in full of your patient portion at every appointment when services are rendered.**

We accept MasterCard, Visa, Discover, cash and checks.
We accept American Express for payments over $500.
We are happy to offer a 5% accounting courtesy for all treatment over $500 that is paid in full prior to treatment commencing that is paid by cash or check only.
If you are in need of an extended finance option, we also work with Care Credit (Healthcare Provider Credit Card). They offer 6 or 12 month interest free payments based on approved credit.

## FOR PATIENTS WITH INSURANCE

■ Your dental benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.**

■ We currently accept most PPO dental plans, but every plan is different and is subject to change at any time. Some plans we are out of network for, and some are in network plans. This is something our office staff with be happy to review with you. If you would like to know your insurance benefits, we will be glad to file a complimentary benefits analysis "Pre-Estimate of Treatment" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you as close to exact out of pocket figure you may require. If your insurance pays less, or does not pay for a service, it is the patient's responsibility. I authorize release of information to my insurance company.

■ Pascia Dentistry requires payment on the day services are rendered. As a courtesy, and to expedite reimbursement, we will file your insurance claims for you. Please understand that your insurance policy is a legal contract between you and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

■ If at any time your dental insurance changes and/or you get new dental insurance, please contact the office to update your insurance information **prior** to any scheduled appointments you may have. If you do not update your new dental insurance at least **48 hours prior** to your scheduled appointment, you may be responsible for paying in full for that appointment and getting reimbursed by your insurance company.

**I have read the Financial Policy. I understand and agree with the above conditions.**

Print name: _____ Date: _____

Patient/Parent Signature: _____

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