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: _____/_____/_____

NICKNAME OR PREFERRED NAME: _____

ADDRESS: _____ APT: _____

CITY: _____ STATE_____ ZIPCODE: _____

HOME PHONE: _____ CELL PHONE: _____

E-MAIL ADDRESS: _____ MARITAL STATUS: _____

SOCIAL SECURITY #: _____ DRIVERS LICENCSE: _____

OCCUPATION: _____

EMPLOYER: _____ BUSINESS TELEPHONE: _____

BUSINESS ADDRESS: _____

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☐

DATE OF YOUR LAST PHYSICAL AND/OR EXAM? _____

PLEASE LIST ANY/ALL MEDICATIONS, DRUGS, AND/OR PILLS YOU ARE TAKING? LIST INDIVIDUALLY NAME AND USE

IF YOU HAVE A LIST – PLEASE LET US SCAN THAT INTO YOUR CHART

Name: _____ Reason Taken: _____ Dosage: _____ Frequency: _____

Name: _____ Reason Taken: _____ Dosage: _____ Frequency: _____

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Name: _____ Reason Taken: _____ Dosage: _____ Frequency: _____

Name: _____ Reason Taken: _____ Dosage: _____ Frequency: _____

Name: _____ Reason Taken: _____ Dosage: _____ Frequency: _____

Name: _____ Reason Taken: _____ Dosage: _____ Frequency: _____

Name: _____ Reason Taken: _____ Dosage: _____ Frequency: _____

ARE YOU ALLERGIC TO ANY OF THE BELOW LISTED? .....YES ☐NO ☐

☐ LATEX ☐ PENICILLIN ☐CODEINE ☐ ERYTHROMYCIN ☐ ASPIRIN

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: **WHEN** _____
- ☐ 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
- ☐ HPV
- ☐ AUTOIMMUNE DISEASE _____
- ☐ BLOOD TRANFUSIONS
- ☐ RHEUMATIC FEVER
- ☐ HEPATITIS A (INFECTIOUS) ☐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? _____

DO YOU SMOKE/VAPE ~ CIGARETTES:☐ YES ☐ NO ~ SMOKE/VAPE MEDICAL MARIJUANA: ☐ YES (DAILY/OFTEN)☐ YES (OCCASIONALLY)☐ NO
CHEW TOBACCO: ☐ YES☐ NO ~ DO YOU DRINK SODA: ☐ YES (DAILY/OFTEN) ☐ YES (OCCASIONALLY) ☐ NO

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? _____
DATE OF LAST DENTAL HYGIENE APPOINTMENT? _____
ARE YOU HAVING PAIN AT THIS TIME? _____
HAVE YOU HAD YOUR WISDOM TEETH EXTRACTED? ☐ YES, ALL ☐ YES, SOME ☐ NO ☐ UNSURE – WHEN (YEAR): _____
HAVE YOU EVER HAD A BAD EXPERIENCE IN A DENTAL OFFICE? _____

*Pascia Dentistry offers Botox – If interested, please let us know and we can schedule a complimentary consultation

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT IF I HAVE ANY CHANGES IN MY HEALTH AND/OR MEDICATIONS TAKEN, I WILL UPDATE PASCIA DENTISTRY. 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 15 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 **15 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.

- It is important to come in regularly for your dental hygiene appointments. If two or more years have passed since you were last seen in our office for your dental hygiene appointment, our office will schedule to update your x-rays and exam prior to scheduling your next dental hygiene appointment.

I fully understand & agree with the above conditions.

Print name: _____ Date: _____

Patient 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.

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 dental situation. It is always our goal to provide our wonderful patients with outstanding dental care.

Please 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 at every dental 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 $1000 that is paid in full prior to treatment commencing that is paid by cash or check only. (Debit cards not included in this discount)
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

■ **Pascia Dentistry is not contracted with any Dental Insurance, and therefore is considered Out of Network with all Dental Insurance plans.** What does this mean for you? Pascia Dentistry strives to provide the highest quality of care to all of our wonderful dental patients. Becoming Out of Network with insurance helps us give patients better access to exemplary care and increased quality time during all dental visits.
If you have a PPO Dental Insurance Plan, that has Out of Network benefits, you will pay for each appointment in full at time services are rendered. Our wonderful front desk team will help you by filing your dental claims to your dental insurance for you. Depending on your individual Out of Network benefits, insurance will send you, the patient, a reimbursement check.
If you would like to have a better idea of what your dental insurance reimburses for out of network benefits, we will be glad to file a complimentary benefits analysis "Pre-Estimate of Treatment" with your insurance company prior to any appointments and treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you better idea of what amount of reimbursement to expect from your insurance. Please note pre-estimates can sometimes take 4-8+ weeks to receive.
I authorize release of information to my insurance company.

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

■ **Pascia Dentistry requires payment on the day services are rendered.** As a courtesy, and to expedite reimbursement, we will file your Dental 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. This will help our office when filing your dental claim to better assist you in receiving any Out of Network Dental Insurance reimbursement.

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

Print name: _____ Date: _____

Patient Signature: _____

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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): _____ Phone # _____

Relationship: _____

Name Printed (Not yourself): _____ Phone #: _____

Relationship: _____

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

CONSENT FOR TREATMENT

I hereby authorize Dr. David T. Pascia, Dr. Kelly Kidwell, Dr. James T. Pascia, 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 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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