Smile

42370 Van Dyke Ave., Suite 101
Sterling Heights, MI 48314
(586) 254-3860

B.A. Giglio, DDS

PATIENT REGISTRATION

Date:

Patient Information:

First Name: Last Name: Middle Initial:

Preferred Name:

Patient is : □ Responsible Party □ Policy Holder

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone: Cell Phone:

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

Birth date: Social Security #:

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

Responsible Party: (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone: Cell Phone:

Birth date: Social Security #:

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

Referred By:_____ Previous Dentist:_____

Emergency Contact (name and phone number):_____

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 Fosmax, Boniva, Actonel, or 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	
Do you need to pre-medicate?	Yes	No	If yes, please explain: _____
Have you had any joint replacement surgeries?	Yes	No	
Have you ever had a skin reaction to metal?	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 Acrylic Metal Latex Local Anesthetics Sulfa

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	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	Bypass Surgery	Yes	No
									Shunts or Stents	Yes	No

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

_____

_____

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 _____

Appreciated Patient Letter

To Our Appreciated Patient,

Our goal is to consistently improve services and quality of care for you, your family and friends. We will treat you in an efficient and cost effective manner, which will make each visit exceptional. The highest compliment our office can receive is the referral of your friends and family. Our patient directive is outlined below:

- Insurance: Treatment recommendations are based on your health, not on your insurance or lack thereof. We expect patients to be aware of their individual benefits. Remember insurance companies are not concerned about your health or wellbeing, we are. As a courtesy, we provide you with an estimate of benefits; however you are fully responsible for any treatment performed. Your benefits are a contract between you and your insurance company and we will not be responsible for what your insurance will or will not cover.

- Timeliness: Our commitment is to see you on time, barred any emergent or unforeseen circumstances. Our expectation is that our patients be on time as well. If you are more than 10 minutes late, you may have to reschedule.

- Missed Appointments: It is critical to reschedule missed appointments in order to avoid setbacks in your care. Failure to keep an appointment not only compromises your health, but it also inconveniences other patients who may have requested your reserved time. If you cannot make an appointment, we expect that a 48 business hour notice be given. Failure to do so will result in a $100 cancellation fee. This fee is not covered by insurance.

- Finances: We strive to run a Zero Balance office focusing on Dentistry not Banking/Accounting. In order to achieve this, we require 50% of your total patient out of pocket expense to reserve any scheduled appointment. We have financial options available for all of our patients. Please speak with Deanna, Jamie or Paula if you have any questions regarding financial options.

- Emergencies: It is our goal to eliminate all potential dental emergencies based on our treatment philosophy. In the rare instance that you do have an emergency, rest assured that we will take care of you. In the case of swelling, bleeding, severe pain that has kept you up at night or requires medication or a restoration in a visible area that falls out, we ask that you call us right away and we will provide you with the next available emergency appointment. We set aside time daily for these types of emergencies.

Yours in Dental Health,
Bruno Giglio, DDS

I have read and agree to the terms of the Appreciated Patient Letter.

_____ _____ _____
(Patient Signature) (Patient's Printed Name) (Date)

_____
(Team Signature)

Smile

EVALUATION

_____ _____

Name Date

1. Do you like the way your teeth look? Yes ( ) No ( )

Explain: _____

2. Are you happy with the color of your teeth? Yes ( ) No ( )

Explain: _____

3. Would you like for your teeth to be whiter? Yes ( ) No ( )

Explain: _____

4. Would you like your teeth to be straighter? Yes ( ) No ( )

Explain: _____

5. Do you have spaces between your teeth that you would like closed? Yes ( ) No ( )

Explain: _____

6. Would you like your teeth to be longer? Yes ( ) No ( )

Explain: _____

7. Do you like the shape of your teeth? Yes ( ) No ( )

Explain: _____

8. Do you have missing teeth that you would like replaced? Yes ( ) No ( )

Explain: _____

9. Do you have old silver fillings that you would like to be replaced with tooth-colored fillings? Yes ( ) No ( )

Explain: _____

10. If you could change anything about your smile, what would you change? Yes ( ) No ( )

Explain: _____