Tellissi Family Dentistry 72695 Highway 111, Ste A8, Palm Desert, CA 92260 P: (760)340-2160 Info@TellissiFamilyDentistry.com

Tellissi Family Dentistry

PATIENT NAME_____**PREFERRED NAME**_____**DATE**_____

Blood Pressure: / Pulse: RA ☐ /LA ☐ Temperature:

MEDICAL HISTORY

Are you under a physician's care now? Yes ☐ No ☐ Why? _____Who?_____Phone_____
Have you ever been hospitalized or had a major operation? Discuss_____Yes ☐ No ☐
Have you ever had a serious injury to your head or neck? Discuss_____Yes ☐ No ☐
Are you on a special diet? Discuss_____Yes ☐ No ☐
Are you allergic to any medications or substances? Please check box below_____Yes ☐ No ☐
☐Aspirin ☐Ibuprofen ☐Acetaminophen☐Penicillin☐Erythromycin ☐Codeine ☐Tetracycline ☐Sulfa ☐ Local Anesthetic
☐Fluoride ☐Acrylic ☐Metals (Nickel, Gold, Silver)☐Latex Rubber ☐Milk ☐Other_____
Women (Please Check):
☐Pregnant/trying to get pregnant ☐Nursing ☐Taking oral contraceptives discuss _____Yes ☐ No ☐

Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes. *If yes to any of the starred conditions, please call prior to your appointment… premedication or changes in medication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/ Surgery*	☐	☐	Prolonged Bleeding (INR>3.5	☐	☐	X-Ray Treatments (Radiation)	☐	☐	Night Sweats	☐	☐	Cold Sores	☐	☐
Heart Murmur of Defect*	☐	☐	Sickle Cell Disease	☐	☐	Chemotherapy	☐	☐	Yellow Jaundice	☐	☐	Fever Blisters	☐	☐
Irregular Heart Beat	☐	☐	Hemophelia	☐	☐	Osteroporosis	☐	☐	Kidney Problems	☐	☐	Herpes	☐	☐
Angina/ Chest Pain	☐	☐	Methhemoglobinemia	☐	☐	Bisphosphanates	☐	☐	Renal Dialysis	☐	☐	Stoke	☐	☐
Heart Attack/ Failure	☐	☐	Leukemia	☐	☐	Osteonecrosis of Jaw	☐	☐	Thyroid Disease	☐	☐	Convulsions	☐	☐
Congenital Heart Disorde	☐	☐	Recent Blood Transfusion	☐	☐	Aredia I.V Reclast I.V.	☐	☐	Parathyroid Disease	☐	☐	Epilepsy or Seizures	☐	☐
Mitral Valve Prolapse*	☐	☐	Taking Blood Thinners?	☐	☐	Zometa I.V.	☐	☐	Arthritis/ Gout	☐	☐	Fainting or Dizziness	☐	☐
Scarlet Fever	☐	☐	Swelling Limbs	☐	☐	Fosamx, Actonel, Boniva	☐	☐	Rheumatism	☐	☐	Glaucoma	☐	☐
Rheumatic Fever*	☐	☐	Lung Disease	☐	☐	Stomach/ Intestinal Disease	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Artificial Heart Valve*	☐	☐	Breathing Problem	☐	☐	Ulcers	☐	☐	Cortisone Medicine	☐	☐	Nervousness	☐	☐
Pacemaker*/ Imp Defrib	☐	☐	Shortness of Breath	☐	☐	Recent Weight Loss	☐	☐	Artificial Joint*	☐	☐	Psychiatric Care	☐	☐
Pulmonary Shunt*	☐	☐	Frequent Cough	☐	☐	Frequent Diarrhea	☐	☐	STDs	☐	☐	Alzheimer's Disease	☐	☐
High Blood Pressure	☐	☐	Hay Fever	☐	☐	Diabetes (HbA1C=)	☐	☐	AIDS	☐	☐	Allergies (Medicines)	☐	☐
Low Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Excessive Thirst	☐	☐	HIV Positive	☐	☐	Allergies (Pollen/Dust)	☐	☐
Bacterial Endocarditis*	☐	☐	Asthma	☐	☐	Hypoglycemia	☐	☐	Genital Herpes	☐	☐	Hives or Rash	☐	☐
Unexplained Fever	☐	☐	Bloody Sputum	☐	☐	Liver Disease	☐	☐	Drug Addiction/ Alcoholism	☐	☐	Need Premedication?	☐	☐
Bruise Easily/ Blood Dise	☐	☐	Emphysema	☐	☐	Hepatitis A (infectious)	☐	☐	Tattoos/ Body Piercing	☐	☐	Ever taken fen-phen?*	☐	☐
Anemia	☐	☐	Tuberculosis	☐	☐	Hepatitis B or C	☐	☐	Sleep Apnea	☐	☐	Cochlear Implants	☐	☐
Coronary Stent*	☐	☐	Cancer	☐	☐	Protease Inhibitor	☐	☐	Hormone Deficiency	☐	☐	History of COVID-19	☐	☐

Have you had any serious illness not checked above? Discuss_____Yes ☐ No ☐
Are you taking any medications, aspirin, vitamins, herbals, pills, or drugs? _____Yes ☐ No ☐
What? _____
_____
Describe any current medical treatment, impending surgery, genetic/ development delay, or other treatment that may possibly affect your dental treatment (i.e. Botox, Collagen Injections)_____
Do you wish to talk to the dentist privately about any problems?_____Yes ☐ No ☐

X_____Date_____
PATIENT SIGNATURE (PARENT OR PARENT GUARDIAN)

Reviewed by Dr.

Date

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DENTAL HISTORY

Primary reason for this dental appointment: examination☐ emergency☐ consultation☐
How would you rate the condition of your mouth? Excellent☐ good☐ fair☐ Poor☐
Previous Dentist
How long have you been a patient? Month___Years___
Date of most recent dental exam _____Date of most recent x-rays_____Date of most recent treatment (other than dental hygiene visit)
I routinely see my dentist every? 3 mo. ☐ 4mo. ☐ 6mo. ☐ Not routinely☐
What is your immediate concern?_____

Personal History

Are you fearful of dental treatment? Yes ☐ No ☐
Have you had an unfavorable dental experience? Yes ☐ No ☐
Have you ever had complications from past dental treatment? Yes ☐ No ☐
Have you ever had trouble getting numb or had any reactions to local anesthetics? Yes ☐ No ☐
Did you every have braces, orthodontic treatment or had your bite adjusted? Yes ☐ No ☐

Smile Characteristics

Is there anything about the appearance of your teeth that you would like to change? Yes ☐ No ☐
Have you ever had your teeth whitened? Yes ☐ No ☐
Have you felt uncomfortable or self conscious about the appearance of your teeth? Yes ☐ No ☐

Bite and Jaw Joint

Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)? Yes ☐ No ☐
Have your teeth changed in the last 5 years, become shorter, thinner or worn? Yes ☐ No ☐
Are your teeth crowding or developing spaces? Yes ☐ No ☐
Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? Yes ☐ No ☐
Do you clench your teeth in the day time or make them sore? Yes ☐ No ☐
Do you have any problems with sleep or wake up with an awareness of your teeth? Yes ☐ No ☐
Do you wear or have you ever worn a bite appliance? Yes ☐ No ☐

Tooth Structure

Have you had any cavities with the past 3 years? Yes ☐ No ☐
Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing food? Yes ☐ No ☐
Do you feel or notice any holes (ie, pitting, craters) on the biting surface of your teeth? Yes ☐ No ☐
Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? Yes ☐ No ☐
Do you have grooves or notches on your teeth near the gum line? Yes ☐ No ☐
Have you ever broken teeth, chipped teeth, or had a tooth ache or cracked filling? Yes ☐ No ☐
Do you frequently get food caught between any teeth? Yes ☐ No ☐

Gum and Bone

Do your gums bleed or are they painful when brushing or flossing? Yes ☐ No ☐
Have you ever been treated for gum disease or been told you have lost bone around your teeth? Yes ☐ No ☐
Have you ever notices an unpleasant taste or odor in your mouth? Yes ☐ No ☐
Is there anyone with a history of periodontal disease in your family? Yes ☐ No ☐
Have you every experiences gum recession? Yes ☐ No ☐
Have you ever had any teeth become loose on their own, or have difficulty eating an apple? Yes ☐ No ☐
Have you ever experience a burning sensation in your mouth? Yes ☐ No ☐

To the best of my knowledge all the preceding answerers are correct. If I have any changes in my health status, I shall inform the dentist and staff at the next appointment without fail.

X_____Date_____
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Reviewed by Dr.

Date

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PATIENT INFORMATION

Patient Name: _____Date: _____
Last, First MI (Preferred Name)
Social Security #_____ Birth Date_____ Gender M / F
Cell_____Phone (Home) _____(Work)_____
Address_____
Street ,City, State, Zip, Code
Out of State Address_____
Street, City, State, Zip, Code
Email Address_____
Occupation_____Employer_____ Best time to call_____
Marital Status: Minor☐ Single ☐Married ☐Divorced☐ Widowed ☐Separated☐
Spouse's or Parent's Name _____Relationship_____
In case of Emergency Contact _____ Phone_____

INSURANCE INFORMATION

Primary:
Name of subscriber _____ Birth date ____/____/____ Social Security # _____
Relationship to Patient: _____ Home Ph. (_____) _____ Work Ph. (_____)_____
Name of Employer:_____
Insurance Company: _____ Group # _____ Union or Local # _____
Ins. Company Address:_____
Address City State ZIP
Secondary:
Name of subscriber _____ Birth date ____/____/____ Social Security # _____
Relationship to Patient: _____ Home Ph. (_____) _____ Work Ph. (_____)_____
Name of Employer:_____
Insurance Company: _____ Group # _____ Union or Local # _____
Ins. Company Address:_____
Street, City, State, ZIP Code
Assignment and release:
I herby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for insurance claims. I authorize that my records can be used by the doctor if he/she so determines.

PERSON RESPONSIBLE FOR ACCOUNT

In consideration of the services rendered to me by this dental office , I am obligated to pay said office in accordance with credit terms and policy.
Please check one: PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ FATHER ☐ MOTHER ☐

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? _____
Family/Friend☐ Internet Search ☐ Television ☐Phone Book ☐ Other_____
Do you live here? Full time Seasonal from_____ to _____
In our efforts to be efficient, conscious of the world we live in, and supportive of protecting our planet we communicate through phone, email and text messages to our patients regarding appointments. Which do you prefer we use to contact you?
Phone☐ Email ☐Phone☐

_____ _____
Signature of patient or parent guardian Date

HIPPA PRIVACY RULE OF PATIENT AUTHORIZATION AGREEMENT

Authorization for disclosure of protected health information for treatment, payment, or healthcare operations.

I,_____(patient's name) understand that as part of my healthcare, Tellissi Family Dentistry originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, any other plans for future care treatment. I understand that this information serves as

- A basis for planning my care and treatment
- A means of communication among the health care professionals who may contribute to my health care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have been offered a copy of **the Notice of Privacy Practices** that provides a more complete description of information uses and disclosures. I understand that as part of my protected health information to another covered entity I have the right to review records. I authorize the disclosure of my protected health information as specified.

PRIVACY RULE FO PATIENT CONSENT AGREEMENT

I understand that:

- I have the right to object to the use of my health information for directory purposes
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Tellissi Family Dentistry is not required by law to agree to the restricted.

X_____Date_____
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PAYMENT OPTIONS AND OFFICE CANCELLATION POLICY

INFORMATION TO OUR PATIENTS

Our mission is to deliver the finest, most cost effective dental care available today. Following diagnosis, the doctor will discuss with you our plan for treatment. We will also discuss the cost of today's and future treatments. Payment for all services is due at the time of treatment. **Because your dental plan may not cover the entire cost of your treatment (i.e. PPO), or is a discount plan (i.e. HMO) for your convenience we offer several payment options that fit your personal budget**.

PAYMENT OPTIONS

1. Cash
2. Check
3. Visa, Apple Pay, G Pay, Samsung Pay, Zelle, MasterCard or American Express
4. CareCredit: a healthcare credit card designed for your health and wellness needs. It's a way to pay for the costs of many treatments and procedures and allows you to make convenient monthly payments.

I understand that I am responsible for my estimated co pay regardless of my insurance coverage. If for some reason the account should be come delinquent, I agree to pay for all interest charged, collection costs and attorney fees.
Our team can customize a payment plan designed specifically for you and your individual finances.

Please indicate below the payment option you wish

1. ☐ Cash
2. ☐ Check
3. ☐ Visa, Apple Pay, G Pay, Samsung Pay, Zelle, MasterCard or American Express
4. ☐ CareCredit

BROKEN APPOINTMENT POLICY

When a patient does not show up for their appointments or cancels too close to their scheduled time, we are unable to fill this appointment time with another patient who desperately needs dental care. This policy is our attempt to ensure that all of our patients receive equal access to the dental care they need.

EXAMPLES OF BROKEN APPOINTMENTS

- **NO SHOW –** Anytime a patient is scheduled for an appointment and they do not come in.
- **LATE CANCELLATION –** Anytime a patient calls and cancels an appointment with **less than 24 business hours** until their scheduled appointment.
- **LATE ARRIVAL –** When a patient arrives late to the scheduled appointment more 10 minutes after their appointment time. The appointment time of the late patient may be given to another patient.

PAITENTS WITH BROKEN APPOINTMENTS WILL BE CHARGED $50.00

Check-in 15 minutes before your appointment time.

This allows for paperwork and financial processes prior to your appointment

No cell phone use in the office…

- We ask that you not use your cell phone inside our office (waiting room and during your appointment)
- This will help us to protect all patients' privacy and to keep a pleasant environment for all.

Confirmation calls are made 48 hours in advance, ultimately it is your responsibility to come in at your scheduled appointment time. Please make sure we have your most current phone number and email.

I have read and understand the information above.

X_____Date_____

PATIENT SIGNATURE (PARENT OR PARENT GUARDIAN)

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ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET & CONSENT FOR SERVICES

PATIENT ACKNOWLEDGMENT O RECEIPT OF DENTAL MATERIALS FACT SHEET

The following document is the Dental Board of California's Dental Materials Fact sheet and its linkage to the DCA website does not constitute and endorsement of the content of the document

A state law passed in 1992 required the Dental Board of California to develop and distribute a fact sheet describing and comparing the risks and efficacy of the various types of dental restorative materials that may be used to repair a dental patient's oral condition or defect. The fact sheet was originally intended for use by dentists to encourage them to discuss the risks and benefits of the various restorative materials with their patients. (Refer to Business & Professions Code section 1648.10.) The Dental Board is obligated to update the fact sheet when they deem necessary. The first DMFS was developed and distributed by the Dental Board in 1993 and was subsequently revised to reflect current science in 2001. However, when new legislation passed in 2001 required the fact sheet be given to patients requiring restorative work, the Dental Board determined that a more "user-friendly" fact sheet was needed. That fact sheet was approved by the Dental Board in May 2004. How do I obtain a copy of the current DMFS? You can obtain a copy at the Dental Board web site at www.dbc.ca.gov/formspubs/index.shtml#pubs or by contacting them at 916.263.2300. Upon request, a copy of the Dental Materials Fact Sheet can be presented to you at the office or sent via email.

I, _____, acknowledge I have read and understood the Dental Materials Fact Sheet dated May 2004.

_____ _____

Signature of Patient or parent guardian Date

CONSENT FOR PATIENT SERVICES

I herby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks; I understand that I can ask for complete recital of any possible complication.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that complete payment is due at the time of service. I also understand that any returned checks or insufficient payments will be assessed a $25 fee and the entire balance will be required to be paid immediately. I agree that in the event my account becomes delinquent due to non-payment and is turned over to an outside collection attorney or agent. I agree to pay all actual reasonable fees, legal fees, cost, expense and court cost incurred in the collection.

As a condition of treatment by this office, financial arrangements must be determined before treatment. As a courtesy to our insurance patients, we file a claim with your dental insurance. We will always do our best to help you maximize your dental benefits, however ultimate responsibility for payment is yours and financial arrangements must be defined prior to beginning dental treatment. We do our best to keep up with constant changes in dental insurance. We ask for you to please check in with the front desk at each visit to make sure there have not been any contractual changes with your particular insurance provider.

I grant my permission to you or your assigned, to telephone me to discuss this statement, my account, appointments or my treatment.

I consent to making of videotapes, photographs, and x-rays, during, and after treatment, and to use the same by the doctor in scientific papers or demonstrations.

I have read to the above conditions of treatment and payment and agree to their content.

_____ _____

Signature of Patient or parent guardian Date