Donna Palmisano, D.D.S.

Prosthodontics | General Dentistry
Skin Care | Beauty Services

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we are happy to help.

Date: _____

Patient Information (confidential)

Name: _____ Birthdate:_____ Soc. Sec. #: _____ ____ _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Email:_____ Gender: ☐ Male ☐ Female

Parent's name if minor: _____ Phone #: _____

Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Pharmacy: _____ Phone # _____

Preferred method of contact: ☐ Cell phone ☐ Home phone ☐ Email

Patient's Employer: _____ Phone #:_____

Emergency Contact Person: _____ Phone #: _____

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

Responsible Party (if someone other than patient)

Person responsible for this account: _____ Relationship to patient:_____

Address: _____ Phone #: _____ Driver's license #: _____

Birthdate: _____ Soc. Sec. #: ____ ___ ____ Is this person currently a patient in this office: Y N

For your convenience, we offer the following methods of payment. Payment in full at each appointment.

Please check the option you prefer: ☐ Cash ☐ Personal Check Credit Card: ☐ Visa ☐ Mastercard ☐ Discover

Insurance Information

Name of Insured: _____ Relationship to patient: _____

Birthdate: _____ Soc. Sec. #: ____ ___ ____ Date Employed: _____

Name of Employer:_____ Work #: _____

Address of Employer:_____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ ID #: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured: _____ Relationship to patient: _____

Birthdate: _____ Soc. Sec. #: ____ ___ ____

Name of Employer:_____ State: _____ Zip: _____

Address of Employer:_____ City: _____

Insurance Company: _____ Group #: _____ ID #: _____

Check all that apply: Receive automated reminders via: ☐ Email ☐ Cell ☐ Both

Patient Medical History

Physician: _____ Phone#: _____
Last Exam Date: _____

Y N 1. Are you under any medical treatment now?
Y N 2. Have you ever been hospitalized for any surgical operation or serious illness within the past 5 years
Y N 3. Are you taking any medication (s) including prescription medicine? If so, please list below

_____ _____
_____ _____
_____ _____

Y N 4. Have you ever taken Fosamax or any bisphosphonate?
Y N 5. Are you wearing contact lenses?
Y N 6. Do you use controlled substances?
Y N 7. Do you use tobacco?

Women Only
Y N Are you pregnant or think you may be pregnant?
Y N Are you nursing?
Y N Are you taking oral contraceptives?

Any Allergies or reactions to the following?
Y N Local Anesthetics (e.g. Novocaine)
Y N Penicillin or any other Antibiotics?
Y N Barbiturates
Y N Sedatives
Y N Iodine
Y N Aspirin
Y N Any Metals (e.g. nickel, mercury, etc.)
Y N Latex Rubber

Health Conditions

Y N Abnormal Bleeding	Y N Cosmetic Surgery	Y N Hemophilia	Y N Rheumatic Fever
Y N Alcohol Abuse	Y N Diabetes	Y N Hepatitis A	Y N Seizures
Y N Allergies	Y N Difficulty Breathing	Y N Hepatitis B	Y N Shingles
Y N Anemia	Y N Drug Abuse	Y N High Blood Pressure	Y N Sickle Cell Disease
Y N Angina Pectoris	Y N Emphysema	Y N HIV + AIDS	Y N Sinus Problems
Y N Arthritis	Y N Epilepsy	Y N Kidney Problems	Y N Stroke
Y N Artificial Bones	Y N Fainting Spells	Y N Liver Disease	Y N Thyroid Problems
Y N Artificial Heart Valve	Y N Fever Blisters	Y N Low Blood Pressure	Y N Tuberculosis
Y N Asthma	Y N Frequent Headaches	Y N Mitral Valve Proplase	Y N Ulcers
Y N Blood Transfusion	Y N Glaucoma	Y N Pace Maker	Y N Venereal Disease
Y N Cancer/Chemotherapy	Y N Hay Fever	Y N Pneumcystitis	Y N Yellow Jaundice
Y N Colitis	Y N Heart Attack	Y N Psychiatric Problems	
Y N Congenital Heart Defect	Y N Heart Surgery	Y N Radiation Therapy	

Patient Dental History

Name of Previous Dentist: _____

Y N 1. Do you gums bleed while brushing or flossing?
Y N 2. Are your teeth sensitive to hot or cold liquids/foods?
Y N 3. Are your teeth sensitive to sweet or sour liquids/foods?
Y N 4. Do you have any sores or lumps in or near your mouth?
Y N 5. Have you ever experienced any Have you ever experienced any of the following problems in your jaw?
Y N Clicking Pain (joint, ear, side of face)
Y N Difficulty in opening or closing
Y N Difficulty in chewing
Y N 6. Have you had any head, neck, or jaw injuries?
Y N 7. Do you have frequent headaches?
Y N 8. Do you clench or grind your teeth?
Y N 9. Do you bite your lips or cheeks frequently?
Y N 10. Have you ever had any difficult extractions in the past?
Y N 11. Do you feel pain to any of your teeth?
Y N 12. Have you ever had any prolonged bleeding following extractions?
Y N 13. Have you had any orthodontic treatment?
Y N 14. Do you wear dentures?

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during this period of such Dental care to third party payors and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent if minor): _____ Date: _____

Doctor's Comments: _____

Signature: _____ Date: _____

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Dr. Donna Palmisano
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Phone:_____ Email: _____

Social Security #: _____ _____ _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time, by contacting:

Contact Person: Danielle Spadoni or Dr. Palmisano
Telephone: (504) 885-2011 Fax: (504) 456-2983
Address: 2901 N. Causeway Blvd., Suite 306, Metairie, LA 70002

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation, of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date:_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign this Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
PLEASE PRINT NAME

_____
SIGNATURE

_____
DATE

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

FINANCIAL POLICY AGREEMENT

We are committed to providing you with the best possible care. If you have dental insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered, unless payment arrangements have been approved in advance by our staff. Any payment arrangements approved will accrue interest at a rate of 21% monthly beginning the day services are rendered. We accept cash, checks, MasterCard, and Visa. We will be happy to process your insurance claim form for your reimbursement.

Returned checks must be taken care of immediately and will be subject to an additional charge of $26.00. Balances older than 60 days may be subject to additional collection fees and interest charges of 15% monthly. Charges may also be made for broken and missed appointments and appointments cancelled without 24 hours advance notice.

Upon verification of insurance any subsequent visits will be filed with your insurance carrier. All deductibles and co-pays must be paid at the time the service is rendered. **It is against Federal Law for us to forgive payment of your deductible and co-payments. (OIG Fraud and Abuse Alert)** If your insurance company does not cover a service or procedure, you will be personally responsible for the total bill. If your insurance company will only send payment to you, we will require you to always pay at the time services are rendered and the insurance claim will be filed for your reimbursement.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay based on “UCR”, defined a Usual, Customary, & Reasonable fees for this region. Thus our fees are considered UCR by most companies. This does not apply to companies who reimburse based on an arbitrary “schedule of fees”, which bears no relationship to the current standard and cost of care in this region.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as dental care providers, our filing of insurance claims is a courtesy that we extend to our patients. All charges are your responsibility from the date the services are rendered.

If you have any questions regarding the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

_____ _____

SIGNATURE DATE