Dr. Francisco Pico-Fazzi, DDS, FADSA, PC
**649 West Germantown Pike**
**Plymouth Meeting, PA 19462**
**610-397-1020 Fax 610-397-1284**

***Today's Date_____***

*(The information requested is necessary for our files and your health, and will be considered confidential)*

***Name_____ Age_____***

***Spouse's Name_____***

***Residence Address_____City_____State_____Zip_____***

***___married _____single __divorced __widowed ___engaged***

***Social Security#_____-_____-____Date of Birth___/____/___***

***Home Phone#_____ Cell Phone#_____***

***Email Address_____***

***Employer_____ Occupation_____***

***Business Address_____ Business Phone#_____***

***Spouse's Employer_____ Occupation_____***

***Business Address _____Business Phone#_____***

***Who may we thank for referring you to my office_____?***

***Who is responsible for the account_____ Relationship to pt._____?***

***Emergency Contact_____ Phone #_____***

***<u>Dental Insurance Information:</u>***
***Name of your dental insurance carrier_____***
***Name of Group Plan_____ Group#_____***
***Pt's relationship to Employee ___Self ___Spouse _____Child***
***Insurance Carrier's Social Security# (if other than patient) _____-____-__***
***Insurance Carrier's Date of Birth ____/____/_____***

***Medical Health Information:***

***Weight_____ Height_____***
***(Please circle)***

***Are you in good health? Yes No***
***Have there been any changes in your health in the past year? Yes No***
***Are you under the care of a physician or specialist? Yes No***
***- If yes for what condition are you receiving care or testing?***
***_____***

***Physician Name_____ Phone#_____***

***Have you had any serious illness, been hospitalized or had an operation within the past 5 years? Yes No***
***-If yes please explain_____***

***Do you have or have you ever had any of the following diseases or problems?***
***Rheumatic fever or Rheumatic Heart Disease? Yes No***
***Heart Murmur or Congenital Heart Lesions or Defects? Yes No***
***Any Cardiovascular Disease Yes No***
***-If yes, please list_____***

***Do you have or have you had any of the following?***
***Allergies Yes No***
***Sinus Problems Yes No***
***Asthma or Hay Fever Yes No***
***Fainting or Seizures Yes***
***NoDiabetes Yes No***
***Hepatitis A, B, or C Yes No***
***Jaundice or liver disease Yes No***
***Tuberculosis Yes No***
***Kidney Problems Yes No***
***High Blood Pressure Yes No***
***Low Blood Pressure Yes No***
***HIV/AIDS Yes No***
***Sexually Transmitted Disease Yes No***
***Blood Transfusion Yes No***
***Blood Disorders Yes No***
***Latex/Adhesive Allergy Yes No***
***-If yes, please explain reactions_____***

***Have you had surgery, or radiation treatment, or chemotherapy, Yes No***
***Treatment of a tumor, growth, cancer, or other condition involving head and neck?***
***-If yes, please explain_____***

***Are you allergic to any medication?*** ***Yes*** ***No***
***-If yes, please list_____***

***Are you allergic to local anesthetic?*** ***Yes*** ***No***

***Do you have any disease, condition, or medical problem not listed?***
***-If yes, please explain_____***

***Are you at this time drug dependent, or have you ever had in the past an addictive drug or medication dependence on pain medication, codeine product, narcotics, etc.? If yes, please explain_____*** ***Yes*** ***No***
***Do you use recreational drugs?*** ***Yes*** ***No***

***Please list any medications: _____***
***_____***

***<u>Women:</u>***
***Are you pregnant or any possibility of being pregnant?*** ***Yes*** ***No***
***-If yes, How many months? _____***
***Are you nursing?*** ***Yes*** ***No***
***Are you taking fertility drugs or treatments?*** ***Yes*** ***No***
***Birth Control?*** ***Yes*** ***No***

***<u>Past Dental History</u>***
***Please briefly describe your dental history or any concerns_____***
***_____***

***Have you had any adverse reactions to dental treatment?*** ***Yes*** ***No***
***-If yes, please explain_____***
***_____***

***<u>Informed Consent</u>***
***The above statements regarding my medical/dental health history are true and correct to the best of my knowledge. I understand that my dental treatment may include the use of local anesthesia and/or medications. I understand the hazards in connection with local anesthesia may include swelling, bruising, tingling, and/or numbness of the lips, tongue, gums, and/or face and possible cardiac arrhythmias. If I have any changes or questions in my medical history or questions concerning my treatment, I will inform the practice. I understand that is my responsibility to keep this information updated with regard to any pertinent changes by informing the Doctor or dental staff. I authorize dental treatment to be rendered by Dr. Francisco Pico-Fazzi and his dental staff, and I assume financial responsibility for treatment.***
***Signature_____ Date_____***
***(Parent or guardian if patient is a minor)***

# ***History and Physical***

***For Doctor Use Only***

***(Please continue to next page)***

***PMH***_____

_____

_____

***PSH***_____

_____

_____

***PAH***_____

_____

_____

***SH***_____

_____

_____

***Meds***_____

_____

_____

***Allergies***_____

_____

_____

***MALLAMPATI Type*** ***I*** ***II*** ***III*** ***IV***

***Height***_____

***Weight***_____

***ASA Type***_____ ***CV***_____

***RESP***_____

***EENT***_____

_____

_____

# Francisco Pico-Fazzi, DDS, FADSA, PC
## Anesthesiology/Anxiety & Pain Control

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**
**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

**OUR LEGAL DUTY**

**We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about privacy practices, out legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect __/__/__, and will remain in effect until we replace it.**

**We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.**

**You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information at the end of this Notice.**

**USES AND DISCLOSURES OF HEALTH INFORMATION**

**We use and disclose health information about you for treatment, payment, and healthcare operations. For example:**

**Treatment: We may disclose your health information to a physician or other healthcare provider providing treatment to you, and/or your insurance company.**

**Payment: We may use and disclose your health information to obtain payment for services we provide to you.**

**Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provide performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.**

**Initials_____**

**Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.**

**TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person the extent necessary to help with your healthcare of with payment for your healthcare, but only if you agree that we may do so.**

**ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.**

**AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.**

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**QUESTIONS AND COMPLAINTS**

**If you want more information about our privacy practices or have questions or concerns, please contact us.**

**If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have communication with you by alternative means or at alternative locations, you may complain to us using he contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.**

**We support your right to the privacy of your health information. We will retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.**

**Contact the office:**
**Telephone: 610-397-1020 Fax; 610-397-1284**
**Address: 649 West Germantown Pike**
**Plymouth Meeting, PA 19462**

**Please sign below in acknowledgement that you received and understand this information. If you wish to have a copy for your personal records please request one at the time of signing.**

**Patient Signature: _____ Date:_____**

# PATIENT AUTHORIZATION

I authorize any holder of Medical or other information about me to release this information to my insurance company, its intermediaries or carriers, to my attorney or another physician's office.

I hereby authorize direct payment of Medical and/or surgical benefits to include major medical benefits to which I am entitled, Medicare, private insurance, and any other health plan to Dr. Franco Pico-Fazzi, DDS, FADSA, PC.

I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.

I understand that, as these services were performed for me or my legal dependent, I am financially responsible for all charges whether or not paid by insurance.

X_____ _____

Signature of Patient or Responsible Party Date

# Franco Pico-Fazzi, DDS, FADSA, PC

**649 West Germantown Pike**
**Plymouth Meeting, PA 19462**
**Phone (610) 397-1020 Fax (610) 397-1284**


## OUR FINANCIAL POLICY

**We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.**

1. **All patients must complete our "Patient Information Sheet" before seeing the doctor.**

2. **We accept cash, check, and most major credit cards as form of payment.**

3. **We can provide financing sources for your treatment.**

## Regarding Insurance

**If you have insurance, we will help you receive the maximum benefits allowed under your coverage. Insurance is a contract between you and your insurance company. We will inform you if we accept your insurance as payment. Any co pays and/or deductibles and any unpaid benefits are your responsibility. We will not become involved in disputes between your and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, usual and customary charges, etc., other than to supply factual information as necessary. You are responsible for the timely payment of your account.**

**If we decide to accept payment from your insurance and your insurance company has not paid us within 30 days, you will receive a bill for the unpaid balance. It will then be your responsibility to contact your insurance company for reimbursement. Late payment charges (5% monthly, 18% yearly interest) are added to unpaid accounts after 60 days from date of services.**

**Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.**

**Responsible Party Signature_____ Date_____**

**Dr. Franco Pico-Fazzi, DDS, FADSA, PC**
**649 West Germantown Pike**
**Plymouth Meeting, PA 19462**
**Phone (610) 397-1020 Fax (610) 397-1284**

# Dental Insurance Explanation

Dear Patient,

In an effort to have a clear understanding about dental/medical insurance, we hereby disclose our insurance policy:

- Dental Insurance is not a guarantee of payment.
- You are responsible for any amount not paid by insurance.
- If you receive an insurance check, it should be forwarded to our office within 5 business days to avoid interest charges and or collections.
- Any deductibles and/or co pays are due at time of service.
- If a claim is denied you are responsible for the balance.
- Once your insurance benefits are exhausted, you are responsible for the full amount charged.
- Any insurance exclusions will be your responsibility 100 %.
- A Credit Card Authorization form must be completed prior to treatment as a method of payment if we do not receive reimbursement from your insurance carrier.

_____

Patient/Guardian Signature Date

**Franco Pico-Fazzi, DDS, FADSA, PC**

**649 West Germantown Pike, Plymouth Meeting, PA 19462**
**Phone (610) 397-1020 Fax (610) 397-1284**
**Dental Anesthesiology/Anxiety and Pain Control**

# PATIENT FEE AGREEMENT

**THE UNDERSIGNED PATIENT AND/OR GUARDIAN INTENDS AND AGREES TO BE LEGALLY BOUND BY THE FOLLOWING CONTRACTUAL TERMS CONCERNING THE PROVISION OF DENTAL SERVICES PROVIDED BY DR. FRANCO PICO-FAZZI:**

1. **Patient will pay for services.**

2. **Patient will be responsible for the payment of all costs and expenses as they become due.**

3. **Dr. Pico-Fazzi will not be obligated to provide services until he is in receipt of all due account balances.**

4. **The patient promises to pay on day of service for expected procedure fee, any additional work not contemplated must be paid within thirty (30) days of the date of the procedure.**

5. **All unpaid balances outstanding for greater than thirty (30) days will accrue interest at the rate of 15% per year compounded on a monthly basis.**

6. **The patient consents to Dr. Pico-Fazzi's termination of all services in any and all cases in the event that the patient fails to pay any bill within thirty (30) days of the date of the procedure.**

7. **The patient understands and acknowledges that the success of treatment depends, in large part, on continuity and follow-up treatment. In the event that the patient discontinues treatment or delays return for treatment with Dr. Pico-Fazzi for any reason, it is understood that the treatment already provided may be compromised, and the patient will be charged again for the additional work needed.**

8. **The patient will be responsible for all costs incurred in the collection of any unpaid balances on a patient's bill including, but not limited to, the filing and service fees for the initiation of a collection action.**

9. **Dr. Pico-Fazzi and staff have explained all options, including that of "no treatment" and all questions have been answered to the patient's satisfaction.**

_____ _____

**Patient/Guardian Signature** **Date Document Signed**

**Plymouth Meeting, PA 19462**
**Phone (610) 397-1020 Fax (610) 397-1284**

# Consent Form And Recognition Of Treatment

I, _____, have been informed by,
Dr. _____, about the reason for treatment, the diagnosis (nature of the problem), prognosis (chances of success), alternative options, risks of the procedure, expectancy of success, and possible consequences if treatment not performed. I consent to treatment.

_____

Patient/Guardian Signature Date

_____

Witness Signature Date

## ***Consent for Radiographs***
## ***&***

# ***Maxillofacial Imaging***

**Our office is equipped with digital radiography and state of the art imaging, including conventional dental radiographs, panoramic radiographs, and 3 dimensional maxillofacial Cone Beam CT scan.**

**We utilize these modalities to diagnose and evaluate conditions of the oral cavity, jaws, and sinuses. Some of these radiographs may take images and view adjacent structures not related to the oral cavity and jaws such as the neck, throat, eyes, cranium, upper spine, nose, ears, base of skull, and other sinus structures.**

**As a dental practice, we are trained to identify abnormalities of the oral cavity with these technologies. It is the patient's option and decision to have an independent medical radiologist read and review the areas not related to dentistry.**

**I, _____, decline the radiologist's interpretation of any radiographs and CT Scans I may receive during treatment.**

**I,_____, consent to have an independent radiologist evaluate the non-dental structures included in my radiographic studies for an additional fee of $175.00.**

_____ _____

**Patient Signature** **Date**

**Francisco Pico-Fazzi, DDS, FADSA, PC**

**649 West Germantown Pike Plymouth Meeting, PA 19462**

# Consent for Oral Cancer Screening

**Our office is equipped with technology that allows us to screen for oral cancer. The fluorescent technology is an optical based technology that allows us to shine a blue light that can identify oral cancer, pre-cancer, and other abnormal lesions at an early stage that cannot be seen by the naked eye.**

**As a dental office we recommend that every patient has this test done at least once a year especially if you have past history of cancer or history in the family of cancer, smoking, chewing tobacco, drinking alcohol, or have had prior biopsies or chronic irritated areas.**

**I, _____, decline the oral cancer screening.**

**I, _____, consent to have the oral cancer screening for an additional fee of $40.00. Our office will submit a claim to your insurance company on your behalf for reimbursement, however there is no guarantee of payment.**

**Should we find a suspicious area, a biopsy will be recommended. There will be an additional charge for this procedure which might be covered by your dental and/or medical insurance. Additionally, a charge to read and interpret the biopsy will be done by the laboratory which will go through your medical insurance carrier.**