VENNERI DENTAL GROUP, P.C.

3040 E. County Line Rd. Hatboro, PA 19040 ~ Phone: 215-675-4090

Medical History Questionnaire

Patient Name:_____ Date of 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. Please answer the following questions carefully and accurately, and explain any "Yes" answers on the line provided.

Are you under a physician's care now? □ Yes □ No If yes, _____

Have you ever been hospitalized or had a major operation? □ Yes □ No If yes, _____

Have you ever had a serious head or neck injury? □ Yes □ No If yes, _____

Do you take, or have you taken, Phen-Fen or Redux? □ Yes □ No If yes, _____

Do you take/have you ever taken Fosamax, Bonivam, Actonel or any other medications containing bisphosphonates? □ Yes □ No If yes, _____

Are you on a special diet? □ Yes □ No If yes, _____

Do you use tobacco? □ Yes □ No If yes, _____

Do you use controlled substances? □ Yes □ No If yes, _____

Are you allergic to any of the following medication? □ Aspirin □ Penicillin □ Codeine □ Sulfa Drugs □ Local Anesthetics

Other: _____

Are you allergic to any of the following materials? □ Acrylic □ Metal □ **Latex** Other: _____

Women: Place a check in each category that pertains to you

□ Pregnant □ Trying to get pregnant □ Nursing □ Taking oral contraceptives Name of Contraceptive: _____

Do you have, or have you ever had, any of the following?

AIDS/ HIV Positive	□ Yes	□ No	Cortisone Medicine	□ Yes	□ No	Hemophila	□ Yes	□ No	Recent Weight Loss	□ Yes	□ No
Alcohol Dependency	□ Yes	□ No	Diabetes	□ Yes	□ No	Hepatitis A	□ Yes	□ No	Renal Dialysis	□ Yes	□ No
Alzheimer's Disease	□ Yes	□ No	Drug Dependency	□ Yes	□ No	Hepatitis B or C	□ Yes	□ No	Rheumatic Fever	□ Yes	□ No
Anaphylaxis	□ Yes	□ No	Easily Winded	□ Yes	□ No	Herpes	□ Yes	□ No	Scarlet Fever	□ Yes	□ No
Anemia	□ Yes	□ No	Emphysema	□ Yes	□ No	High Blood Pressure	□ Yes	□ No	Seizures	□ Yes	□ No
Angina	□ Yes	□ No	Epilepsy	□ Yes	□ No	High Cholesterol	□ Yes	□ No	Shingles	□ Yes	□ No
Arthritis	□ Yes	□ No	Excessive Bleeding	□ Yes	□ No	Hives or Rash	□ Yes	□ No	Sickle Cell Disease	□ Yes	□ No
Artificial Heart Valve	□ Yes	□ No	Excessive Thirst	□ Yes	□ No	Hypoglycemia	□ Yes	□ No	Sinus Trouble	□ Yes	□ No
Artificial Joint	□ Yes	□ No	Fainting / Dizziness	□ Yes	□ No	Irregular Heartbeat	□ Yes	□ No	Spina Bifida	□ Yes	□ No
Asthma	□ Yes	□ No	Frequent Cough	□ Yes	□ No	Kidney Problems	□ Yes	□ No	Stomach/Intestinal Disease	□ Yes	□ No
Blood Disease	□ Yes	□ No	Frequent Diarrhea	□ Yes	□ No	Leukemia	□ Yes	□ No	Stroke / TIA	□ Yes	□ No
Blood Transfusion	□ Yes	□ No	Genital Herpes	□ Yes	□ No	Liver Disease	□ Yes	□ No	Swelling of Limbs	□ Yes	□ No
Breathing Problems	□ Yes	□ No	Glaucoma	□ Yes	□ No	Low Blood Pressure	□ Yes	□ No	Thyroid Disease	□ Yes	□ No
Bruise Easily	□ Yes	□ No	Hay Fever	□ Yes	□ No	Lung Disease	□ Yes	□ No	Tonsillitis	□ Yes	□ No
Cancer	□ Yes	□ No	Heart Attack / Failure	□ Yes	□ No	Mitral Valve Prolapse	□ Yes	□ No	Tuberculosis	□ Yes	□ No
Chemotherapy	□ Yes	□ No	Heart Disease / Trouble	□ Yes	□ No	Osteoporosis	□ Yes	□ No	Tumors or Growths	□ Yes	□ No
Chest Pains	□ Yes	□ No	Heart Defibrillator	□ Yes	□ No	Pain in Jaw Joints	□ Yes	□ No	Ulcers	□ Yes	□ No
Cold Sores/Fever Blisters	□ Yes	□ No	Heart Murmur	□ Yes	□ No	Psychiatric Care	□ Yes	□ No	Venereal Disease	□ Yes	□ No
Convulsions	□ Yes	□ No	Heart Pacemaker	□ Yes	□ No	Radiation Treatments	□ Yes	□ No	Yellow Jaundice	□ Yes	□ No

Please explain any "Yes" answers _____

_____

Have you ever had any serious illness not listed above? □ Yes □ No If yes, please explain_____

_____

Are you required to pre-medicate prior to having any dental work completed? □ Yes □ No If yes, please explain _____

_____ Prescribing Doctor: _____

PLEASE COMPLETE THE REVERSE SIDE OF THIS PAGE

PLEASE LIST (any and all that apply):

Current Medications & Dosage	Reason for Medication	Surgeries/Operations (Type and Year)

Physician's Name: Date of Last Exam:

Phone Number:

Address:

DENTAL HISTORY:
Name of Previous Dentist: _____ Date of Last Exam: _____

PLEASE EXPLAIN:

Why did you leave your last dentist? _____

Are there any situations that make you apprehensive at the dental office? _____

_____

Please answer the following questions carefully and accurately, and explain any "Yes" answers on the line provided.

Have you ever had any complications after dental treatment? □ Yes □ No If yes, _____

Are you dissatisfied with your teeth and/or their appearance? □ Yes □ No If yes, _____

Do you have spaces between your teeth that bother you? □ Yes □ No If yes, _____

Have you had orthodontic treatment? If Yes, list dates. □ Yes □ No If yes, _____

Are your teeth sensitive (i.e. temperature, pressure)? □ Yes □ No If yes, _____

Do you have any loose teeth? □ Yes □ No If yes, _____

Do you brush your teeth? If Yes, how often? □ Yes □ No If yes, _____

Do you floss your teeth? If Yes, how often? □ Yes □ No If yes, _____

Do your gums bleed while brushing or flossing? □ Yes □ No If yes, _____

Have you ever been diagnosed with gum disease (Periodontal Disease)? □ Yes □ No If yes, _____

Do you have a hypersensitive gag reflex? □ Yes □ No If yes, _____

Have you ever experienced any problems or discomfort in your jaw? □ Yes □ No If yes, _____

Have you ever had oral surgery (extractions, grafting)? □ Yes □ No If yes, _____

Do you wear dentures? If Yes, please list date of placement. □ Yes □ No If yes, _____

Comments (or anything else you would like us to know?):

_____

_____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take because of errors or omission that I may have made in the completion of this form. I understand, it is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent or Guardian: _____ Date: _____

VENNERI DENTAL GROUP, P.C.

3040 E. County Line Rd. Hatboro, PA 19040 ~ Phone: 215-675-4090

Patient Information (PLEASE PRINT)

First Name: _____ MI: ____ Last Name: _____ Prefix/Suffix: _____

Preferred Nickname: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Social Security #: _____ Gender: _____

Drivers Lic#: _____ Marital Status: O Married O Single O Divorced O Separated O Widowed

Email Address: _____ Name of Spouse/ Parent/Guardian (if a minor) _____

Employer: _____ Phone #: _____

Whom may we thank for referring you? _____

Whom should we contact in case of an emergency? _____ Phone #: _____

Responsible Party (COMPLETE IF OTHER THAN PATIENT)

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Social Security #: _____ Gender: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: O Self O Spouse O Child O Other

Insured's Social Security #: _____ Insurance ID #: _____

Insured's DOB: _____ Group #: _____

Employer: _____ Insurance Company: _____

Employer's Address: _____ Ins Co.'s Address: _____

City, State, Zip: _____ City, State, Zip: _____

Phone Number: _____ Phone Number: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: O Self O Spouse O Child O Other

Insured's Social Security #: _____ Insurance ID #: _____

Insured's DOB: _____ Group #: _____

Employer: _____ Insurance Company: _____

Employer's Address: _____ Ins Co.'s Address: _____

City, State, Zip: _____ City, State, Zip: _____

Phone Number: _____ Phone Number: _____

PLEASE COMPLETE THE REVERSE SIDE OF THIS PAGE

Thank you for choosing Venneri Dental Group, P.C. as your dental provider. We are committed to the latest in technical advances delivered with comfort and care. Below is some important information, which we would like to share. All patients must complete and sign this form, prior to receiving services.

CANCELLED / MISSED APPOINTMENT POLICY:
When you schedule a dental appointment, Venneri Dental Group, P.C. reserves time in the schedule that is no longer available to other patients.

As the time is reserved especially for you, if you are unable to keep your commitment your advanced notice will allow another patient access to dental care. To cancel or reschedule an appointment, you must call Venneri Dental Group, P.C. during regular business hours. Venneri Dental Group, P.C. reserves the right to charge a $35 broken appointment fee for appointments that are missed and/or canceled with less than two (2) business days' notice. If the broken appointment was an extended appointment, scheduled for 60 minutes or more, the fee is $60. These fees are not covered by dental insurance. In the event that multiple appointments are missed and/or cancelled with less than two (2) business days' notice, the patient may be placed on a list to be called when an opening allowing the necessary time needed for the patient's dental care, arises in the schedule. At all times, Venneri Dental Group, P.C. reserves the right to dismiss the patient(s).

HIPAA Consent:
With my consent, Venneri Dental Group, P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operation (TPO). I also authorize Venneri Dental Group, P.C. to call my home, cell, or designated location, send email and/or text messages, and leave a message on voicemail, or in person, in reference to any items that assist Venneri Dental Group, P.C. in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results, among others. With this consent, Venneri Dental Group, P.C. may mail to my home, text to my cell, or other designated location any items that assist the practice in carrying out TPO, such as patient statements.

Please list the persons with whom we may discuss your information, if needed.

Name: _____ Phone #: _____ Relationship to the patient: _____

Name: _____ Phone #: _____ Relationship to the patient: _____

As a service to our patients, we provide courtesy appointment and recare reminder messages, and other important messages, such as office closures, by using text messages. We also may send text messages notifying you of promotions our practice may offer from time to time. By providing your cellphone number, you consent to receiving text message reminders and notifications at this number. You may opt out of receiving text messages by texting STOP in reply to the message at any time.

Mobile Phone #: _____

We may also provide these messages by e-mail. By providing your e-mail address, you consent to receiving e-mails.

E-mail Address: _____

By signing this form, I am consenting for Venneri Dental Group, P.C. to the use and disclosure of my PHI to carry out TPO. I have the right to refuse to sign or revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. This consent will not expire, and will remain in effect indefinitely, or until I request in writing to cancel my authorization. I understand the above guidelines, have had the opportunity to read the HIPAA Notice of Privacy Practices, and to ask questions, and upon my request will be given a copy of the privacy notice.

I HAVE READ ALL OF THE POLICIES ABOVE AND AGREE TO ABIDE BY THE TERMS AND CONDITIONS AS STATED IN EACH.

_____ _____
Signature of Patient (Parent/Guardian if Minor) / Responsible Party Date

_____ _____
Signature of Venneri Dental Group, P.C. Employee Date

VENNERI DENTAL GROUP, P.C.
FINANCIAL RESPONSIBILITY

Patient Name (PLEASE PRINT): _____

For all patients, it is necessary to have an easily understood financial responsibility policy whether or not there is dental insurance coverage involved. If there is dental insurance, as a result of the many different and confusing insurance company reimbursement policies, it is important for patients to understand how Venneri Dental Group (shown here as VDG) will assist you with your insurance. The treatment recommended is based on the patient's need and not by what any insurance company will cover. Your treatment should not be governed by your insurance contract, which is a contract between you and your insurance company. While we would be happy to answer questions to help you understand your insurance coverage, your best resource would be to check with your insurance carrier directly. All patients/responsible parties must sign this form prior to being treated.

- It is necessary for you to provide the office with complete insurance information for all carriers with whom you are insured at the time of service. **Prior to or at each scheduled appointment**, we need you to provide your current insurance information for our files, to ensure claim(s) can be accurately submitted. It is your responsibility to inform VDG of any insurance changes (i.e. employer, insurance plan, etc.) or any personal changes (i.e. name, address, phone number, etc.) that will impact your insurance coverage.
- As a service to our patients, we will submit your insurance claim to your primary insurance company. VDG will provide all the information necessary to help you receive maximum benefit from your insurance coverage. However, it is the responsibility of the patient/insured to determine and understand the details, restrictions, and benefit limitations of your particular policy. VDG is not responsible for whether or not a service performed is a covered benefit and therefore will not assume responsibility for the insurance company's refusal to pay a claim. Composite (white) fillings are often the choice of treatment to restore a tooth. Some employers have chosen a dental insurance plan which may pay partial or no benefits for these types of restorations. If you need to decline white fillings, you must inform the Doctor(s) prior to treatment. PLEASE BE AWARE MOST INSURANCE PLANS HAVE A MAXIMUM AMOUNT OF BENEFITS THAT THEY WILL PAY PER PLAN YEAR.
- If a claim is denied, we will research why the rejection occurred and either resubmit to insurance or bill you the appropriate balance. If the claim is denied a second time, any appropriate balance becomes the responsibility of the Patient/Responsible Party and should be paid to us directly. You may then contact your insurance company for further information and reimbursement.
- If the patient has coverage with an additional insurance company, we will submit all secondary claims directly, along with a copy of the Explanation of Benefits from the primary insurance. If the primary insurance payment is sent to the insured, the insured must provide the Explanation of Benefits to VDG in order for additional insurance to be submitted. Otherwise, submission for additional insurance is the responsibility of the patient/insured. As coordination of benefits is unpredictable, payment from the additional insurance coverage may be paid directly to the insured.
- Insurance is a patient's benefit designed to assist in the financial obligation for services rendered to the patient by the dental providers of VDG. The patient is the one receiving the dental service and therefore the Patient/Responsible Party is ultimately responsible for payment for all charges on the account regardless of any insurance coverage. It is important you understand that your dental benefits policy may have an "allowable amount" ("Allowable") for each procedure, which is determined by the benefit policy you have with the insurance company and may or may not equal the Doctor's fee. Under the benefit contract, the insurance company may pay a percentage of the Allowable.
- At, or prior to the time of service, VDG will estimate the anticipated insurance payment and will collect from the Patient/Responsible Party the estimated balance due along with any deductible which may apply. VDG cannot guarantee any estimated coverage. After the primary insurance payment is received, the Patient/Responsible Party will be billed for any difference between the estimated balance due and the actual balance due. Upon receipt of the statement, the remaining patient balance must be paid in full within thirty (30) days, unless a signed financial agreement has been approved. If the insurance payment is greater than what was anticipated, we will either refund the amount to the Patient/Responsible Party or leave the credit balance on the patient's account to be applied toward future treatment.
- In the event the patient does not have insurance coverage or the insurance company sends the insurance payment directly to the insured, CHARGES FOR SERVICES ARE DUE AND PAYABLE IN FULL AT THE TIME SERVICES ARE RENDERED, unless a signed financial agreement has been approved.
- For your convenience, we accept cash, check, Visa, Mastercard, Discover, and American Express (subject to change at the discretion of VDG). Dental payment plans through third party lenders, are also an option, upon application and approval from the lender. VDG reserves the right to charge the account a fee for any check returned unpaid by the bank. If a check is returned unpaid by the bank, your personal checks will no longer be accepted.

Insurance benefits are estimates only. I understand the insurance company makes the final determination of payment and eligibility and they may pay less than the actual bill for services and less than what may have been predetermined by them. I understand that I am responsible for any co-payments and deductibles, along with any payment for procedures that my insurance company does not cover. I am also responsible for any balance due because of insurance claims not paid within 60 days of service. I authorize VDG to release any information, including diagnosis and records of treatment rendered during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to VDG, insurance benefits, otherwise payable to me.

I understand VDG reserves the right to charge a monthly statement fee, or for any outstanding balance due to the office not paid within 60 days of the date of invoice, the amounts due, and interest charge of one and one half percent (1.5%) per month (18% annual) or the maximum allowed by law, whichever is less, and to use a Collection Agency for the collection of my account and will charge my account any collection fees involved. If VDG initiates legal action to collect amounts due, the Court of appropriate jurisdiction for VDG shall be Hatboro District Court located at 420 S. York Road Condo C in Hatboro, PA. Should the amount being collected exceed the allowable amount to be litigated in said court, litigation shall be in the Montgomery County Court of Common Pleas located at 2 E. Airy St., Norristown, PA, and I further agree to pay pre and post-judgement interest, court costs and attorney's fees as allowed by law and the court. I further understand that if my account is sent to collections, all scheduled appointments will be cancelled, until the account is paid in full. At all times, VDG reserves the right to dismiss patient(s) from the practice for the below responsible party.

I have read and understand the above, and I agree to be responsible for payment of all services rendered and any statement charges/collection fees accumulated on the patient's account.

_____ _____

Name of Patient (Parent/Guardian if Minor) / Responsible Party (PLEASE PRINT) Social Security Number of Responsible Party

_____ _____

Signature of Patient (Parent/Guardian if Minor) / Responsible Party Date

Signed at: Venneri Dental Group, P.C. 3040 E. County Line Rd. Hatboro, PA 19040

VENNERI DENTAL GROUP, P.C.

CONSENT TO PROCEED

Patient Name (PLEASE PRINT): _____

I authorize the Doctor(s) of Venneri Dental Group, P.C. and/or such associates, hygienists, or assistants, as may be designated, to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent, including those related to restorative, palliative, therapeutic, or surgical treatments.

I understand the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally, drops of local anesthetic may contact the eyes and facial tissue and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate TMJ disorder. Gums and surrounding tissues may also be sensitive or even possibly quite painful both during and after completion of treatment. Although rare, it is possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of the dental treatment items including but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. The unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of any minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me, if necessary, and I have been given the opportunity to ask questions.

_____

Name of Patient (Parent/Guardian if Minor) / Responsible Party (PLEASE PRINT)

_____ _____

Signature of Patient (Parent/Guardian if Minor) / Responsible Party Date

VENNERI DENTAL GROUP, P.C.
3040 E. COUNTY LINE ROAD
HATBORO, PA 19040
(215)675-4090

Notice of Privacy Practices

Patient Acknowledgment

Patient Name_____ Date of Birth_____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make each of the following purposes: Treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use of disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A Description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights has been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice up n request.

This Practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practice's on request.

Signature:_____Date:_____

Relationship to patient (if signed by a personal representative of (patient):_____