

Luminous Smiles

* Dr. Mary Di Lisio, DMD *

10 Fox Valley Center

Arnold MO 63010

Phone# 314-894-9700

Fax# 636-548-8131

Patient Information

Patient Name: _____

Gender: Male ___ Female ___

Family Status: Married ___ Single ___ Child ___ Other _____

Birth Date: _____ Social Security # _____

Email Address: _____

Home # _____ Mobile # _____

Work # _____ Ext. _____

Home Address: _____

City, State, Zip Code _____

In case of an emergency, who should be notified? Also include their relationship to you.

Name: _____ Relationship: _____

Telephone #: _____

Dental History

Reason for visiting today _____

Are you having any pain or discomfort at this time? _____

Are you nervous about having dental treatment? _____

Have you ever had an adverse reaction to dental anesthetic? _____

Does the crowding of your teeth bother you? Yes ___ No ___

Are you interested in a straighter whiter smile? Yes ___ No ___ Eventually _____

Date of last cleaning or exam? _____

Have you had braces? Yes ___ No ___

Medical History

Physician's Name: _____ Phone # _____

Pharmacy Name: _____ Phone # _____

Please put an X if you have any **allergies** to the following:

Aspirin ___ Erythromycin ___ Sulfa ___ Penicillin ___

Tetracycline ___ Codeine ___ Ciprofloxacin ___ Keflex ___ Dental Anesthetics ___ Jewelry ___ Latex ___

Other: _____

(Continued on next page→)

Have you had any serious illnesses or operations? _____

If yes, describe _____

Do you need to take premedication before dental work? _____

FEMALES ONLY:

Women: Are you pregnant? _____ Nursing? _____

Taking birth control pills _____

Medications: Please bring your list of medications and OTC with you to your appointment

Please list any medications, vitamins, or supplements that you are currently taking:

Have you ever taken a bone replacement therapy medication, such as Fosamax, Prolia or Boniva? If so, which one and when?

Indicate which of the following conditions you have or have had. By putting an X on the line in front of the condition listed, you are indicating a “Yes” response. By leaving the line blank, it will indicate a “No” response.

- | | | |
|---|--|--|
| <input type="checkbox"/> Pre-med Amoxicillin | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Pre-med Clindamycin | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Pre-med Other | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Use Tobacco |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Artificial Bones | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Artificial Heart valve | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Teeth grinding or clenching |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV + Aids | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Cancer-Chemo | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Snoring while sleeping |
| <input type="checkbox"/> Congenital Heart | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Jaw joint problems |
| <input type="checkbox"/> Contrast Dye | <input type="checkbox"/> Mitral Valve | |
| <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> Other | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Radiation Therapy | |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Rheumatic Fever | |

Repeatedly Missed or Cancelled Appointments: When a patient repeatedly cancels appointments, it can disrupt our practice's schedule and affect the care provided to other patients. Therefore, if multiple appointments are cancelled or missed, we reserve the right to dismiss you as a patient at Luminous Smiles. So we urge you to schedule appointments on a day that you will for sure be able to come to your appointment. We understand unforeseen circumstances and patient dismissal is on a case by case basis.

Signature X _____

Person Responsible for Account & Insurance

Person responsible for account: _____ Relation to patient _____

Birthdate: _____ SS#: _____ Address: _____ Phone#: _____

City: _____ State: _____ Zip: _____

Person responsible employed by: _____

Insurance company: _____ Subscriber ID# _____

Group#: _____ Is patient covered by additional insurance Yes ___ No ___

Additional Insurance Plan: _____ Subscriber ID#: _____

Group#: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF OFFICE AND PRIVACY POLICIES

Please initial the statements below to acknowledge that you have read and understand these policies:

X ***Luminous Smiles may require patients to have a credit card on file before services are provided.*

X ***There will also be an added separate collection fee of 100% to any balance if your account is sent to collections.*

X ***We make every effort possible to have your dental claims paid by your insurance.*

When we have exhausted all attempts of payment from your insurance the balance of your account must be paid in full immediately.

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I, _____, have received a copy of this office's Notice of Privacy Practices
(please print name above)

X _____ Date: _____

Signature