LEONE DENTAL
— GROUP —

Frank R. Leone and Lucy B. Rossi-Leone, DDS PLLC
402 Main Street, Armonk, NY 10504

Patient Information

Patient Name: ____ Date: ________________________

Date of Birth: ________________________________ Sex: M/F ____________________

Address: ____

City: ___________________________ State: ______________________________ Zip Code: ______________________

Home Phone: __________________________ Cell Phone: _____________________ Work Phone: __________________

Email Address: ____

Emergency Contact Name: ____ Number: _________________________

Reason for Appointment: ____

Dental Insurance Information

Insurance Plan Name: ____

Policyholder: __________________________________ DOB: ______________________ SS#: ______________________

Policy Number: ____ Group Number: ____________________________

Policyholder Employer: ____

Claims Mailing Address and Phone Number: ____

____

Name of Physician/and their specialty ____

Most recent physical examination ______________________________ Purpose ____________________

What is your estimate of your general health? □ Excellent □ Good □ Fair □ Poor

DO YOU HAVE or HAVE YOU EVER HAD: **YES NO**

1. Hospitalization for illness or injury ____________________
2. an allergic reaction to
   - ❑ aspirin, ibuprofen, acetaminophen, codeine
   - ❑ penicillin
   - ❑ erythromycin
   - ❑ tetracycline
   - ❑ sulpha
   - ❑ local anesthetic
   - ❑ fluoride
   - ❑ metals (nickel, gold, silver, ______________)
   - ❑ later
   - ❑ other ____________________________________
3. Heart problems, or cardiac stent within the last six months__
4. History of infective endocarditis ______________________
5. Artificial heart valve, repaired heart defect (PFO) _________
6. Pacemaker or implantable defibrillator _________________
7. Artificial prosthesis (heart valve or joints) _______________
8. Rheumatic or scarlet fever ___________________________
9. High or low blood pressure __________________________
10. A stroke (taking blood thinners) _______________________
11. Anemia or other blood disorder _______________________
12. Prolonged bleeding due to a slight cut (INR > 3.5) _________
13. Emphysema, sarcoidosis _____________________________
14. Tuberculosis _____________________________________
15. Asthma ____
16. Breathing or sleep problems (i.e. snoring, sinus) __________
17. Kidney disease ____________________________________
18. Liver disease ____________________________________
19. Jaundice ____
20. Thyroid, parathyroid disease, or calcium deficiency ________
21. Hormone deficiency _________________________________
22. High cholesterol or taking statin drugs _________________
23. Diabetes (HbA1c = __________) _______________________
24. Stomach or duodenal ulcer ___________________________
25. Digestive disorders (i.e gastric reflux) ___________________

YES NO

26. Osteoporosis/osteopenia (i.e taking bisphosphonates) ___
27. Arthritis ____
28. Glaucoma _______________________________________
29. Contact lenses ___________________________________
30. Head or neck injuries ______________________________
31. Epilepsy, convulsions (seizures) _____________________
32. Neurologic problems (attention deficit disorder) ________
33. Viral infections and cold sores _______________________
34. Any lumps or swelling in the mouth __________________
35. Hives, skin rash, hay fever __________________________
36. Venereal disease _________________________________
37. Hepatitis (type_______) _____________________________
38. HIV / AIDS ______________________________________
39. Tumor, abnormal growth ___________________________
40. Radiation therapy _________________________________
41. Chemotherapy ___________________________________
42. Emotional problems _______________________________
43. Psychiatric treatment ______________________________
44. Antidepressant medication __________________________
45. Alcohol/drug dependency ___________________________

ARE YOU:

46. Presently being treated for any other illness ___________
47. Aware of a change in your general health _____________
48. Taking medication for weight management (i.e. fen-phen)
49. Taking dietary supplements _______________________
50. Often exhausted or fatigued _______________________
51. Subject to frequent headaches _____________________
52. A smoker or smoked previously _____________________
53. Considered a touchy person _______________________
54. Often unhappy or depressed _______________________
55. FEMALE – taking a birth control pills _________________
56. FEMALE – pregnant _______________________________
57. MALE – prostate disorders _________________________

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose
____________	____________________	____________	____________________
____________	____________________	____________	____________________
____________	____________________	____________	____________________
____________	____________________	____________	____________________

Ask for the an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

Patient's Signature ______________________________________ Date ____________________

Doctor's Signature ______________________________________ Date ____________________

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Notice of Privacy Practices Patient Acknowledgement

I, ______________________________________ hereby acknowledge that I have received a copy of Frank R. Leone and Lucy B Rossi-Leone, DDS PLLC Notice of Privacy Practices. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice. The notice includes:

- A statement that this practice is required to maintain privacy of protected heath information.
- Types and uses disclosures that the practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
- A description of the other purposes for which this practice is permitted to use my health Information without further written consent or authorization.
- A description of other uses and disclosures that will be made only with my authorization and that I may revoke that authorization.
- My individual rights with respect to protected health information briefly described:

  1. The rights to complain to the Secretary of HHS if I believe my rights have been violated.
  2. The right to request restrictions.
  3. The right to receive a copy of protected hearth information.
  4. The right to obtain a paper copy of the Notice of Privacies from this practice upon request.

With my permission Frank R. Leone and Lucy B. Rossi-Leone, DOS PLLC may use and disclose my protected health information to carry out treatment, payment and health-care operations. They may call and leave a message via phone or email and I have the right to request restrictions.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions. I understand that I can obtain the current Notice of Privacy Practices upon request.

____ Date: _________________________
Patient / Guardian Signature

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Financial Policy

The office of Frank R. Leone and Lucy B. Rossi-Leone, DDS PLLC is a fee-for-service practice. For your convenience we accept Check, Cash, Pay pal Card, and All Major Credit Cards including but not limited to: Visa, MasterCard, American Express, Discover, and Diners Club.

Patient financing is also available thru Citi Health-Card with available 0% interest financing, a good option for long term treatment.

We strive to deliver the finest care at the most reasonable cost to our patients. Therefore, payment is due at the time service is rendered unless other arrangements have been made in advance. If you have questions regarding your account, please contact us at (914) 273-2333. Many times, a simple telephone call will clear up any misunderstandings.

Your dental plan is a form of compensation provided by your employer. You can expect the carrier (insurance company) to reimburse you for a portion of our fee. That portion is determined by the contact between your employer and the insurance company. The higher the premium paid by your company, the more generous the reimbursement.

Although we are not a party to the contractual arrangement with your insurance company, we do want to help you receive the maximum reimbursement to which you are entitled. As a convenience to you, we will process your insurance claims in order for you to receive the maximum benefit. We will also gladly provide dental x-rays and a written diagnostic report should your insurance company have any questions about the services provided. However, this being a fee for service practice, you acknowledge that you are personally responsible for the balance on your account and you agree to pay according to the terms and conditions of this office's financial policy.

Signature of Patient or Legal Guardian: ____

Patient's Name: ____ Date: _________________________

Print Name of Patient or Legal Guardian: ____