Welcome!

Welcome to our practice! Our office emphasizes preventive care and restorative and cosmetic procedures in a clean, healthy manner.

Enclosed please find the forms new patients need to complete. Please complete the forms **before** the day of your visit and **bring them with you or email them to us (filled out completely)** for your visit. This will allow us to start your appointment on time. I addition, please bring your insurance information as well so that we can properly submit your claims.

Your first visit allows you to meet Dr. DeForno. He will sit down with you and discuss your concerns, reviewing both your medical and dental history. Because our practice is designed to help you improve your health in many ways (not just your teeth), Dr. DeForno will review some of the factors that may be beneficial to your treatment in an integrative manner. Discussions will include toxic materials, such as mercury, fluoride, nickel and other non-biocompatible materials that may damage your health and suggestions for specific nutritional supplements that may improve your overall health. You will have a full examination performed and intraoral photographs as well as digital x-rays taken if needed. We will also do a free mercury vapor screening.

Your second visit will address your hygiene needs, with our hygienist, who will assess your oral health including an evaluation for possible gum disease. Assuming your oral hygiene is good, she will clean, scale and polish your teeth (all without fluoride) and make recommendations for oral care procedures and products to help maintain your dental health. Should you need restorative dental treatment, additional time will be put aside after your hygiene visit to consult with our office manager and/or Dr. DeForno to review treatment, fees, payment options, insurance details and appointment times.

We are always happy to review any aspect of your dental care at any time, please feel free to call or email our office should any additional questions arise.

We thank you in advance for **refraining from the use of any perfume or cologne for any of your visits** due to the sensitivities that many of our patients have.

We look forward to meeting you and welcoming you to our dental family! Please visit our website at www.integrativedentistryofchestercounty.com prior to your first visit to learn more about our office.

340 North Pottstown Pike (Route100)
PO Box 449
Exton, PA 19341

Phone: 610-363-1980
Fax: 610-363-7798

INTEGRATIVE DENTISTRY of Chester County

Patrick E. DeForno, DMD, FICOI
www.integrativedentistryofchestercounty.com
610.363.1980

Personal Information

Patient Last Name:_____ First:_____ Middle:_____

Birth Date:_____ Social Security Number:_____

Home Address:_____ City_____ State_____ Zip_____

Best Contact Number:_____Land/Mobile Text: Yes/No

Alternative Number:_____Land/Mobile Text: Yes/No

Employer:_____ Occupation:_____

Preferred Email Address:_____

Alternate Email Address:_____

Spouse/Parent/Guardian Information

Name:_____

Birth Date:_____ Social Security Number:_____

Home Address:_____

Best Contact Number:_____Land/Mobile Text: Yes/No

Alternative Number:_____Land/Mobile Text: Yes/No

Employer:_____ Occupation:_____

Preferred Email Address:_____

Alternate Email Address:_____

Do you have children? (Names & Ages):_____

Insurance Information

Insured's Name:_____ Birth Date:_____

Employer:_____ Dental Insurance Co:_____

Group #:_____ ID#:_____

Relationship to Patient:_____

Previous Medical/Dental Information

Medical Physician Name _____ City State _____

Date of Last Medical Visit _____ Reason _____

Dentist Name _____ City State _____

Date of Last Dental Visit _____ Reason _____

Date of Last Complete Series X-rays _____

Why did you leave your last dentist? _____

How did you hear about our office? _____

Past and Present Health History

Aids/Immune Disease	Y N	Asthma or Bronchitis	Y N
Hepatitis	Y N	Tuberculosis	Y N
Rheumatic Fever	Y N	Thyroid Condition	Y N
Heart Valve Replacement	Y N	Anemia	Y N
Joint Replacement	Y N	Cancer	Y N
Mitral Valve Prolapse	Y N	Chemically Dependent	Y N
Pacemaker	Y N	CBD oil use	Y N
High Blood Pressure	Y N	Tobacco use	Y N
Heart/Chest Pain	Y N	HPV	Y N
Bleeding Tendency	Y N	Lyme Disease	Y N
Heart Attack/Stroke	Y N	Arthritis	Y N
Convulsions	Y N	Anxiety	Y N
Lung/Liver/Kidney Disease	Y N	Frequent Headaches	Y N
Diabetes	Y N	**Sleep Apnea**	**Y N**
Acid Reflux _____	**Y N**		
Allergies:		**Allergies:**	
Codeine	Y N	Aspirin/Tylenol	Y N
Penicillin	Y N	Sulfa Drugs	Y N
Erythromycin	Y N	Fruits or Flavors	Y N
Clindamycin	Y N	Latex	Y N
Tetracycline	Y N	Metals	Y N
		Acrylics	Y N

Are you currently pregnant or nursing? Y N

Do you need to premedicate with antibiotics before dental treatment? Y N

Do you smoke? Y N If yes, how much per day? _____

Do you get Herpes lesions (cold sores)? Y N If yes, how often per year? _____

Are you being treated by a physician now? Y N If yes, for what condition? _____

List any medications you are now taking and the reason for taking.

_____

_____

_____

Do you like your smile? Y N What about your smile would you change if possible?_____

_____

Are you aware of the health dangers of mercury? Y N

Are you aware of the dangers of fluoride? Y N

Are you concerned about the mercury fillings in your mouth? Y N

Would you like us to send a report of our dental findings to any healthcare provider? Y N

If yes to the above question, please provide us with that provider(s) name and address (below).

_____

_____

_____

I consent to necessary treatment by Dr. Patrick DeFomo, DMD, as it will be explained to me, along with possible side effects, in advance. I understand that regardless of my insurance coverage, I am financially responsible to Dr. Patrick DeFomo, DMD for my account. I understand there may be a charge for appointments missed or cancelled by me without 48-hour advanced notice, unless my allotted time can be appointed to another patient. I permit Dr. Patrick DeFomo, DMD to release my records, as may be necessary to physicians, dentists, attorneys, other health care providers and insurance companies involved in my health care.

DATE: _____ SIGNATURE: _____

(AT NEXT CHECK UP) I have reviewed this form. There are no changes to my health at this time.

DATE: _____ SIGNATURE: _____

FOR DENTAL STAFF ONLY

I have reviewed this form with the patient and have initialed below.

DATE/REVIEWER

_____ _____

_____ _____

_____ _____

_____ _____

Patrick DeForno DMD

340 N. Pottstown Pike

Exton, PA 19341

610.363.1980

Acknowledgement of Receipt of Notice of Privacy Policies and Authorization to Release & Discuss Dental Information with Friends and/or Family

I, _____, acknowledge that I have been provided a Notice of Privacy Practices and have been offered a paper copy.

The HIPAA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. **Spouses are not automatically included; their names must be explicitly stated below**. You may opt out by checking the "Do not Release Information" box below.

Authorization to speak with family/friend (including spouse)

I give the following named person(s) authorization to take messages or speak with the office of Patrick DeForno DMD, on my behalf regarding **(please check all items authorized).**

Name of authorized person(s):_____**Relationship:**_____

Phone Number_____

___Appointments ___Financial ___Dental Treatment ___Insurance ___Other (explain)_____

Name of authorized person(s):_____**Relationship:**_____

Phone Number_____

___Appointments ___Financial ___Dental Treatment ___Insurance ___Other (explain)_____

Authorization to Leave Health Information by Alternate Means

I authorize Patrick DeForno DMD and staff to use the following telephone numbers provided on the Patient Registration Form to leave messages on voice mail for reminder calls and other patient matters.

___Home Phone ___Work Phone ___Cell Phone

_____ DO NOT RELEASE INFORMATION TO ANYONE

I understand that my express consent is required to release any health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

Patient's Name:_____ Date of Birth_____

Signature_____ Date_____

Office Financial Agreement

Thank you for choosing our office to meet your dental needs. We believe you will find our practice to be very special and your interactions with us unique, positive and caring. Nothing is more important to us than your comfort and absolute satisfaction with all aspects of your dental care.

We will clearly communicate your **estimated** financial obligations involved with your dental treatment plan. Our staff is committed to helping you find a way to afford this investment in your dental care.

PAYMENT POLICY

Full payment is required at the time of service from all patients that are not covered by a CIGNA PPO (in network) dental plan, unless payment arrangements have been made ahead of time with the office manager. As a courtesy, we will file your dental claim for you. It is the patient's responsibility to pay for treatment at time of service. We ask that you provide our office with the details of your insurance plan and any changes. Please note, many services are partially covered or not covered at all by your plan and every insurance plan has its own unique quirks, exceptions, limitations, maximums, deductibles and fee schedules, therefore we recommend a pre-authorization of recommended treatment.

Note: any procedures involving laboratory fabricated restorations require 1/2 down of total due at preparation appointment.

Payment Options

- **Cash or Check:** For any payments exceeding $2,000 per patient, we are happy to offer a 5% courtesy adjustment with cash or check.
- **Credit Cards:** For your convenience, we accept Visa, MasterCard and Discover
- **Payment Plans:** For patients who desire a monthly payment plan, two options are available.
    - A two month, in-office, payment plan (with no interest or finance fees – first half due at time of service and second half due one month from the first payment.)
    - **Care Credit** (with an approved credit application) allowing the patient to choose several payment options over six months or longer.
- **Seniors:** For our patients aged 60 or older, a 5% courtesy adjustment will be applied on all services, with payment at time of service **and** a 5% discount will be applied for any treatment paid by cash or check over $1000. (Does not apply to outside financing or our in office dental savings plan).

If the patient's account is outstanding more than 60 days from the treatment date there will be interest charged at the rate of 1.39% per month (18% per year) and patient agrees to pay this interest. Should it become necessary, the patient agrees to pay all attorney and/or collection agency fees should their account become delinquent.

_____ _____

SIGNATURE **DATE**

04/22

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APPOINTMENT CANCELLATION POLICY and CONFIRMATION SYSTEM

Cancellation Policy

Every Patient is carefully scheduled in order to allow the necessary time to complete their treatment and to provide the quality experience and care we are proud to provide. There are times my patients require urgent or emergency treatment, and therefore require an appointment as soon as possible. Unfortunately, many offices overbook their schedule expecting that a few patients will not keep their appointment. We do not schedule our patients in this fashion. Your appointment time has been reserved specifically for you! Therefore, if you cannot keep your appointment, we ask you give appropriate advance notice. This time can be allocated to those patients in urgent need or treatment.

We ask for a minimum of 2 business days' notice if your appointment must be changed or cancelled. In the event notice is not given, or, if you do not show for your appointment, you will be billed a broken appointment fee ($45 per hour for hygiene appointments and $100 per hour for doctor appointments). Please note if you have scheduled multiple family members and cancel less than 48 hours in advance, a broken appointment fee will be charged for each family member. **It is our wish to never have to charge a patient for broken appointments and that each patient understands this critical aspect of our relationship and its importance.**

Confirmation System

- Fourteen days prior to your appointment you will receive a "save the date" email or text (if you have provided us with your cell phone number and or email address)
- Five days in advance of the appointment an automated reminder is sent via email or text message. You should confirm your appointment at this time.
- One or two business days prior to your appointment, we will call to confirm your appointment and if we do not speak with you personally, we will ask for a return call. **Note: It is important for you to return this call or your appointment may be given to another patient.**

We value the relationship we have with you! Our entire team is dedicated to providing you with the highest level of care. If you have questions or concerns about any of the above, please contact our office and speak with one of our office staff.

Patient Signature _____ Date _____

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Patient Supplement List

Patient Name: _____ Date: _____

Supplement	Brand	Taken How Often?	Dosage	Reason for Taking

It is important to complete this form with precise dosage and brand for your initial consultation.

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