JOSEPH E. MAURIELLO, D.D.S.
VIVIAN RIVELO-MAURIELLO, D.M.D.

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Home Phone._____

Cell Phone _____

E-mail _____

Date_____

Name_____ Soc. Sec.#_____
Last Name First Name Initial

Address;_____

City_____ State,_____ Zip,_____

Sex ☐ M ☐ F Age____ Birthdate ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by_____ Occupation-_____

Business Address _____ Business Phone_____

Whom may we thank for referring you?

In case of emergency who should be notified?_____ Phone- _____

Primary Insurance

Person Responsible for Account_____ _____
Last Name First Name Initial

Relation to Patient -_____ Birthdate_____ Soc. Sec.# _____

Address (If different from patient's)_____ Phone_____

City_____ State_____ Zip_____

Person.Responsible Employed By,_____ Occupation-_____

Business Address s_____ Business Phone_____

Insurance Company

Contract # _____ Group#_____, Subscriber#,_____

Names of other dependents covered under this plan_____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name,_____ Relation to Patient._____ Birthdate._____

Address (If different from patient's)_____ Phone_____

City_____ State_____ Zip,_____

Subscriber Employed by_____ Business Phone _____ -

Insurance Company._____ Soc. Sec. #_____

Contract#_____ Group#_____ Subscriber#._____

Names of other dependents covered under this plan_____

Please Complete Both Sides

Dental History

Reason for Today's Visit ----------

Former Dentist ----------

Address, _____

Date of last dental care _____ Date of last dental X-rays ----------

Check (./) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleecling gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sen_sitivity when biting
- ☐ Sores or growths inyour mouth

How _often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates, _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (./) if you have or have had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems

Describe. _____

- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS
List medications you are currently taking:

_____

_____

ALLERGIES

_____

_____

Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

I agree that if the account has to be referred to a collection agency to pay an additional 1/3 (33.33%) of the amount of the debt, plus reasonable attorney fees, plus 18% interest, plus court cost.

I understand that if I fail to show for an appointment, or do not give a twenty-four-hour notice of cancellation, I will be billed $75.00 per hour scheduled.

Signature _____ Date ----------

Payment is due in full at time of treatment unless prior arrangements have been approved.