CHEVY CHASE
COSMETIC & IMPLANT
DENTISTRY

Dr. Flavio H Rasetto DDS, MS
Diplomate American Board of Prosthodontics

Patient Information

Patient Name: ____ **Date:** ________________________

Last, First MI (Preferred Name)

Gender: M ☐ F ☐ Other ☐ **Birthdate** ___________________ **Soc. Sec.:** ___________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Military Service Member: ☐ Yes ☐ No

Home Phone: _________________ **Work Phone:** ________________ Ext. _____ **Mobile Phone:** _______________

☐ I agree to receive notifications/reminders by phone and/or text message

☐ I do NOT agree to receive notifications/reminders by phone and/or text message

Address: ____

Street City State Zip Code

E-mail: ____

☐ I agree to receive correspondences/notifications/reminders by email

☐ I do NOT agree to receive correspondences/notifications/reminders by email

Employer Name: ____ **Status:** ☐ Full ☐Part-Time ☐Retired

Address: ____

Street City State Zip Code

Responsible Party

Name: ____

Last, First, MI (Preferred Name)

Home Phone: ____________________Work Phone: _____________ Ext. ______ Mobile Phone: ________________

Address: ____

Street City State Zip Code

Employer Name: ____ **Status:** ☐ Full ☐Part-Time ☐Retired

Address: ____

Street City State Zip Code

Emergency Contact

Contact Name: ____________________________________ **Mobile Phone:** _____________________________

Referral Information

Whom may we thank for referring you to our office? ____

Preferred Pharmacy Information

Pharmacy Name______________________ **Location** _________________________________**Phone #**_________________________

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Dental Insurance Information (Fill in OR we can scan your card)

Name of insured_______________________________ **Relationship to patient**__________

Birthdate______________ **SS#**________________

Name of employer________________________ Work phone_____________

Address of employer____

Insurance company ______________________Ins. Co. address____________________

Member/Subscriber ID# ____________ **Group #** _____________ Ins. Co. phone___________

Do you have any additional insurance (secondary)? ☐ Yes ☐ No ***If yes, complete below***.

Name of insured_______________________________ **Relationship to patient**__________

Birthdate______________ **SS#**________________

Name of employer________________________ Work phone_____________

Address of employer____

Insurance company ______________________Ins. Co. address____________________

Member/Subscriber ID# ____________ **Group #** _____________ Ins. Co. phone___________

Health Information

Physician's name: ______________ Physician's phone: ______________

Most recent visit to physician? ________ Reason: ______________

Do we have permission to consult with your physician? ☐Yes ☐No

Are you currently seeing a physician for treatment of a recent or ongoing medical condition? ☐Yes ☐No

If yes, for what condition ________________________________

When was your last complete physical including blood tests? ________________

Have you been hospitalized or had major surgery? ☐Yes ☐No

If yes, please explain: ____________________________________

Have you ever been advised to take antibiotics before dental appointment? ☐Yes ☐No

If yes, please explain: ____________________________________

Have you ever had a serious medical trouble associated with any dental experience? ☐Yes ☐No

If yes, please explain: ____________________________________

Patient initials: ________

Are you taking any medications, pills or drugs? ☐Yes ☐No

If yes, please explain: ____________________

Are you currently receiving **intravenous** Bisphosphonates? ☐Yes ☐No

If yes, for how long: ____________________

Do you take, or have taken, Phen-fen or Redux? ☐Yes ☐No

If yes, please explain: ____________________

Do you take, or have taken, Zometa or Fosamax? ☐Yes ☐No

If yes, please explain: ____________________

Do you smoke or use other tobacco products? ☐Yes ☐No

If yes, please explain: ____________________

Are you **allergic** to any of the following substances?

☐Aspirin ☐Penicillin ☐Tetracycline ☐Erythromycin ☐Sulfa ☐Latex
☐Acrylic ☐Metal ☐Barbiturates ☐Dental Anesthetic ☐Tranquilizers ☐Codeine
☐Other: ____________________

Have you ever had an **adverse reaction** (nausea, dizziness, hives, rash, difficulty breathing, etc.) with any **medicine?**

☐Yes ☐No If yes, please explain which medicine & type of reaction

____

____

Please mark any past or current conditions:

☐	Jaw Joint Pain	☐	Impaired Eyesight / Glaucoma
☐	Arthritis / Gout	☐	Hearing Aid / Hearing Disorder
☐	Venereal Disease	☐	Kidney Condition: Shunt / Dialysis
☐	Epilepsy / Seizures	☐	Frequent Mouth Sores or Lesions
☐	Ulcers	☐	Positive HIV; AIDS; AIDS related complex
☐	Osteoporosis/Osteopenia	☐	Autoimmune disorder
☐	Organ Transplant	☐	Parkinson's Disease
☐	Depression / Anxiety	☐	Drug / Alcohol Addiction
☐	Severe Headaches/Migraines	☐	Steroid (prednisone cortisone) Therapy
☐	Artificial Joint(s)		

If yes, which joint(s): __________ Date of Replacement(s): __________

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☐ Liver Condition

If yes, indicate condition(s) (circle): Jaundice; Cirrhosis; Hepatitis Type A, Type B, Type C, Non-specific

☐ Cancer

If yes, type: ___________________________

Treatment (**circle all that apply**): Surgical Chemotherapy Radiation

Endocrine:

☐ Thyroid Disease

☐ Diabetes

If yes, complete the following: Your last Hemoglobin A1c: ___________________________

(Circle) Type I Type II How often do you have HbA1c tested? 3mo 6mo 12mo

Do you require Insulin? ☐Yes ☐No

How often do you check your blood sugar: __________________

Circulation:

☐ Arterio / Atherosclerosis

☐ High Cholesterol

☐ High / Low Blood Pressure

☐ Mitral Valve Prolapse

☐ Heart Murmur

☐ Angina (chest pain)

☐ Congestive Heart Failure

☐ Heart Surgery: (circle) Bypass, Valve, Other

☐ Rheumatic Fever; Rheumatic Heart Disease

☐ Pacemaker; If yes, Date placed:_______

☐ Heart Attack(s); If yes, date: _________

☐ Stroke

☐ Blood / Bleeding Disorder

☐ Congenital Heart Defect

Respiratory:

☐ Chronic Lung Disease

☐ Asthma

☐ Hay Fever / Allergies

☐ Emphysema

☐ Tuberculosis

☐ Ever Exposed to TB

☐ Persistent Cough or Cough up Blood

☐ Chronic Sinus problems

☐ **Current** Use of Tobacco

Type: (circle) Cigarettes/Snuff / Chew/Cigar/Pipe How many per day? _____________ Years of Use _______________

☐ **Past history** of Tobacco Use If yes, When quit ______________________

Women Only:

☐ Pregnant / Trying to become pregnant If yes, expected delivery date: ______________

☐ Nursing ☐ Taking Contraceptives ☐ Are you going or gone through menopause

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Dental Health History

Name of previous Dentist: ______________________________ Date of last exam: ______________________

Do your gums bleed while flossing or brushing?	☐Yes ☐No		
Do you experience sensitivity to hot/cold/sweet/sour?	☐Yes ☐No		
Do you feel pain to any of your teeth?	☐Yes ☐No		
Do you have any sores or lumps in or near your mouth?	☐Yes ☐No		
Have you had any head, neck or jaw injuries?	☐Yes ☐No		
Have you ever experienced the following problems with your jaw?		Clicking	☐Yes ☐No
		Pain (joint, ear, face)	☐Yes ☐No
		Difficulty opening/closing/chewing	☐Yes ☐No
Do you have frequent headaches?	☐Yes ☐No		
Do you clench or grind your teeth?	☐Yes ☐No		
Do you bite your lips or cheeks frequently?	☐Yes ☐No		
Have you ever had any difficult extractions?	☐Yes ☐No		
Have you ever had prolonged bleeding following extractions?	☐Yes ☐No		
Have you ever had orthodontic treatment?	☐Yes ☐No		
Do you wear dentures or partials?	☐Yes ☐No	If yes, date of placement _______________	
Have you ever had oral hygiene instructions for teeth and gums?	☐Yes ☐No		
Do you like your smile?	☐Yes ☐No		

Herbal Medication / Supplements / Prescriptions:

Are you taking any of the following herbal medications supplements? **(Circle any / all that apply)**

Echinacea	Licorice	Ginseng	Ephedra/Ma Huang	Garlic/Ajo	St. John's Wort	
Gingko	Valerian	Ginger	Coenzyme/Q10	Feverfew	Goldenseal	Saw Palmetto

Please list all: Prescription medications, herbal medications (other than indicated above) & vitamins or supplements that you are currently taking.

Name of Medication | Dosage | Condition / Reason you are taking

____

____

____

____

____

____

Patient initials: _______________

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Cancelation/Missed appointment Policy

Patients are to notify the office **during business hours** and **greater than 48 hours** prior to appointment date, failure to do so will
result in a **cancelation fee of $50.00.**

Patients who **miss their appointments** will be applied a **fee of $50.00 for appointments of an hour duration**.
For **missed appointments greater than an hour** the fee applied **will be determined by the provider** based on time/procedures scheduled for that appointment.

Financial/Payment/Insurance Policy

Payment is due at the time of services rendered.
Although we are out of network providers, we do submit the claims to your insurance company, and they reimburse the patient based on their insurance coverage.
Forms of payment: cash, all credit cards are accepted, personal check and third-party financing (Lending Club, Care Credit if approved).
Any returned checks will be assessed a $35.00 fee.
Late payments: greater than 60 days overdue will be assessed a monthly finance charge of 1.5 % thereafter.
Outstanding balances: greater than 90 days overdue will be sent to collection.
We advise that you please contact us with any financial concerns so we can work with you and address them as soon as possible.

Consent for Photography

Our dental providers take photographs as a tool to enhance the understanding of your dental health and possible need for treatment.
We also request a photograph be taken for your chart.
Do you consent to have photographs taken? ☐ Yes ☐ No Signature____________________________

Consent for use and Disclosure of Health Information

Section A: PATIENT GIVING CONSENT

Name: ____________________________ SSN: ______________
Address: ____________________________ Telephone: ______________

Section B: TO THE PATIENT, PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: before signing this form, you will consent to our disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations, via phone, fax, email, and mail.

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Notice of Privacy Practices: you have the right to read our Notice of Privacy Practices before you decide whether to sign this consent.
Our notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we
may make of your protected health information, and of other important matters about your protected health information.
A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practice as described in our notice of Privacy Practices. If we change our Privacy Practices,
we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected
health information that we maintain.
You may obtain a copy of our Notice of Private Practices, including any revisions of our Notice, at any time by contacting:
Dr. Flavio H. Rasetto Telephone**:** (301) 652- 9717 **Address:** 5454 Wisconsin Ave., Suite 1500. Chevy Chase, MD 20815
Right to Revoke: You will always have the right to revoke this consent at any time by giving us written of your revocation submitted to
the Contact Person listed above. Please understand revocations of this consent will not affect any action we took in reliance on this
consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature: I, ________________________, have had full opportunity to read and consider the contents of this Consent form and your
notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use disclosure of my
protected health information to carry out treatment, payment activities and health care operations.

Signature: ____ Date: ______________________

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________ Relationship to Patient: _______________

If/When applicable:

Revocation of Consent

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment, activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent
before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me
after I have revoked my Consent.

Signature: ____ Date: ___________________________