LuAnne M. Curatola, D.D.S.
Joseph A. Zagami, D.D.S.

Patient Information
Health History

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Welcome to our practice:

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Today's date:			
First Name:	**MI:**	**Last Name:**	
I prefer to be called (nickname, etc.):		☐Male ☐Female	
Address:	**City:**	**State:**	**ZIP:**
Date of birth:		**Social security no.**	
Home phone:	**Work phone:**	**Cell phone:**	
E-mail:			
Contact Preference:	☐Home ☐Work ☐Cell ☐E-mail		
Emergency Contact Person:		**Relationship:**	**Number:**
Whom may we thank for referring you?			

Dental Insurance:
Please make sure that the information given is for you dental insurance, not medical. They are often administered by different insurance companies. Check with you Benefits Coordinator if you are unsure.

Primary Carrier	**Secondary Carrier (If Applicable)**
Insurance co. name:	**Insurance co. name:**
Mailing address of claims:	**Mailing address of claims:**
Group no. (Plan or Policy no.):	**Group no. (Plan or Policy no.):**
Insured's I.D. #:	**Insured's I.D. #:**
Insured Person's name *(if different from own)*:	**Insured Person's name *(if different from own)*:**
Relationship to Patient:	**Relationship to Patient:**
Date of birth:	**Date of birth:**
Insured social security:	**Insured social security:**
Insured Employer's name:	**Insured Employer's name:**

Drs. Curatola & Zagami
Our family... redefining dentistry for your family...

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Health History

Please check if you have had any of the following:

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- ☐ Allergies Hay Fever Seasonal
- ☐ Allergies to Medications
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Problems
- ☐ Blood Disease/Transfusion
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Cancer
  Type:
- ☐ Circulatory Problems
- ☐ Cold Sores/Mouth Sores
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Eating Disorders
- ☐ Emphysema / Bronchitis
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Heart Problems
  Type:
- ☐ Hepatitis A B C
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Immune System Problems
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Mental Health Disorder
- ☐ Mitral Valve Prolapse
- ☐ Nerve Damage
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizure Disorders
- ☐ Sexually Transmitted Disease
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Persistent Swollen Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or Growth
- ☐ Ulcer

Other Conditions not listed:

Have you been Hospitalized or under the care of a medical doctor during the past 2 years? ☐Yes ☐No		
If yes, for what?		
Hospital or Physician's name:	Phone Number:	
Are you currently taking any medications or drugs? (including regular doses of over-the-counter medicines, vitamins and supplements ☐Yes ☐No If Yes, please list:		
Do you use Tobacco? ☐Yes ☐No	Do you use Alcohol? ☐Yes ☐No frequency?	Do you use any other Controlled Substance? ☐Yes ☐No
Women: Are you pregnant or think you may be pregnant? ☐Yes ☐No		
Are you nursing? ☐Yes ☐No		
Are you taking birth control pills? ☐Yes ☐No		

Are you aware of having an allergic (or adverse) reaction to any of the following?

- ☐ Anesthetics
- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Iodine
- ☐ Jewelry/Metals
- ☐ Latex
- ☐ Penicillin or Other Antibiotics
- ☐ Sedative
- ☐ Sulfa Drugs
- ☐ Tetracycline
- ☐ Other_____

Patient Acknowledgement and HIPAA Update

Please read and sign below:

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentists or any other member of their staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Guardian_____ **Date**_____

In an effort to comply with Federal Privacy Practices, please read and sign below:

I certify that I am aware of the Federal Privacy Practices, and/or have been given a notice of such from the office of Drs. Curatola & Zagami. I understand that I will receive postcards, letters, internet correspondences, and phone calls at any of the contact information I provide to this practice. I also understand that I must personally notify the practice should I not wish to receive any of the above correspondences or notifications.

Signature of Patient or Guardian_____ **Date**_____

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Dental History

Reason for visit:
Approximate date of last dental exam: Last teeth cleaning: Last dental x-rays:
IMPORTANT: If you have had dental x-rays taken within the last year, please ask your previous dentist to e-mail them in JPEG format to: curatola.zagami@gmail.com
Do you have any dental questions or concerns you'd like to discuss?
Are you currently in pain? ☐Yes ☐No If so, please describe:
Have you ever had any serious problem associated with previous dental treatment or dental emergencies? ☐Yes ☐No
If so, please describe:
How often do you brush your teeth? _____ times a _____. How often do you floss? _____ times a _____.
What type of toothbrush do you use? Manual Powered
Do you ever feel (or have you ever been told) that you don't have fresh breath? ☐Yes ☐No
Do you avoid brushing any part of your mouth because of pain? ☐Yes ☐No If yes, what part?
Which types of food cause you twinges of pain: ☐Hot ☐Cold ☐Sweet ☐Sour ☐None
Do your gums feel tender or swollen? ☐Yes ☐No Do you have any cold sores/ mouth sores/ mouth ulcers? ☐Yes ☐No
If so, please describe:
Do you chew on only one side of your mouth? ☐Yes ☐No If so, explain:
Do you clench or grind your jaws while sleeping or during the day? ☐Yes ☐No Do your jaws ever feel tired? ☐Yes ☐No
Do you still have your wisdom teeth? ☐Yes ☐No
Do you snore when sleeping? ☐Yes ☐No Have you ever been diagnosed with Sleep Apnea? ☐Yes ☐No
Previous dentist's name: Phone: City: E-mail:
Why are you changing dentists?
Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most) If over 3, please explain:

Have you ever been treated for any of the following?			
Periodontal disease/gum treatment	☐Yes ☐No	Jaw joint pain (TMJ/TMD)	☐Yes ☐No
Orthodontic treatment/braces	☐Yes ☐No	Teeth grinding or bite adjustments	☐Yes ☐No
Oral surgery/teeth extractions	☐Yes ☐No	Dental Implants	☐Yes ☐No
Bite plate/mouth guard	☐Yes ☐No	Serious injury to the mouth or head	☐Yes ☐No

Smile Analysis

Are you delighted with your smile? ☐Yes ☐No Please rate you smile from 1 to 10 (1=I hate my smile, 10=awesome)___
Would you like to have whiter teeth? ☐Yes ☐No Would you like to have straighter teeth? ☐Yes ☐No
If you could change anything about your smile, what would it be? (please check any of the following that apply)

☐ Color of your teeth	☐ Too much or too little of teeth show when you smile	☐ Gaps between your teeth
☐ Size/Shape of your teeth	☐ Too much or too little of gum shows when you smile	☐ Alignment of your teeth
☐ Other:		

What (if any) personal or professional benefit might you gain if you had a gorgeous smile?
Please add anything you feel is important:

330 W. 58th. St. Suite 605 NY, NY 10019 212-586-3585 www.curatola.zagami@gmail.com www.creatingNYCsmiles.com

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Financial Options and Obligations

We offer a wide range of financial options in order to pay for your dental treatment.

INSURANCE

We can receive payment towards your account from any insurance plan in which you can choose your own dentist (PPO, PDO, Premier, etc.). We do this as a courtesy to you, our patient. While we do our best to estimate your "out-of pocket" expense based upon the information we receive from your plan, we are not responsible for any denial or reduction of payment as determined by your insurance. We can never guarantee payment from your insurance. After your dental insurance has paid for dental services rendered, you may have an outstanding balance. This balance may include any deductibles, copayments, denials, and non-covered services. For balance owed, we require a credit card authorization.

Credit Card: (Please check one) ☐Visa ☐MasterCard ☐Discover ☐Amex ☐CareCredit

First Name:	Last Name:
Card#:	Expiration Date:
CVD#:	Zip:
Signature:	Date:

FORMS OF PAYMENT ON BALANCE DUE

In order to facilitate access to the very best health care possible, you may choose from any of the following: Cash, Visa, MasterCard, American Express, Discover, Money Order, Personal Checks, or CareCredit.

FINANCIAL ARRANGEMENTS

Several in-office payment arrangements are available for account balances. All fees will be disclosed to you and financial arrangements discussed and confirmed prior to treatment.

Pay as You Go: You may choose to pay your obligation with cash, check or credit card at the time of your visits.

For Balances on Extensive Treatment Plans:

Prepayment in Full: A Prepayment Courtesy will be given for payment in full before or at the first treatment visit (does not include CareCredit payment).

Split Payment: One half or one third of the total treatment is due at the preparation visit; the second and third payments due in the middle of treatment; and final payment at the cementation visit of the dental appliance.

CareCredit: With fast online approval CareCredit can help you get the healthy, radiant smile you've always wanted with the card designed specifically for your dental needs. CareCredit offers No Interest and low monthly payment options, no up-front costs, no prepayment penalties, and no annual fees. CareCredit is a medical/dental line of credit, and can be subject to interest fees as set forth by CareCredit. Pre-approval is required. Go to www.carecredit.com for complete information and pre-approval.

Please Read and Sign the Following:

I understand that if I become delinquent on my account, my account will be turned over to a collection agency, and I will subsequently be reported to the credit bureaus. In case of total default, I promise to pay any collection costs and attorney fees incurred to collect on this account.

I certify that I have read, fully understand, and accept the above financial policy.

Signature of Patient or Guardian_____ **Date**_____