Welcome, and thank you for selecting our dental healthcare team!

We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us . . . we will be happy to help.

Patient #:

Soc. Sec. #:

Patient Information (Confidential)

Date:

Name	Date of Birth:	Home Phone:
Address	City/State	Zip Code:
Check Appropriate Box: Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐		
Patient's or Parent's Employer:		Work Phone:
Business Address:	City/State:	Zip Code:
Spouse or Parent's Name:	Employer:	Work Phone:
If Patient is a Student, Name of School/College:		City/State:
Whom may we thank for referring you?		
Person to contact in case of emergency:		Phone:
Email Address:		

Responsible Party

Name of person responsible for this account:		Relationship to Patient:
Address:		Home Phone:
Driver's License:	Date of Birth:	Financial Institution:
Employer:		Work Phone:
Is this person currently a Patient in our office? Yes ☐ No ☐		

Insurance Information

Name of Insured:		Relationship to Patient:
Date of Birth:	Soc. Sec. #:	Date Employed:
Name of Employer:		Work Phone:
Address of Employer:	City/State:	Zip Code:
Insurance Company:	Group #:	Union or Local #:
Ins. Co. Address:	City/State:	Zip Code:
How much is your deductible:	How much have you used:	Max. Annual Benefit:
Do you have any additional insurance? Yes ☐ No ☐ If yes, complete the following:		
Name of Insured:		Relationship to Patient:
Date of Birth:	Soc. Sec. #:	Date Employed:
Name of Employer:		Work Phone:
Address of Employer:	City/State:	Zip Code:
Insurance Company:	Group #:	Union or Local #:
Ins. Co. Address:	City/State:	Zip Code:
How much is your deductible:	How much have you used:	Max. Annual Benefit:

PHILIP S. DESENZE, D.D.S, PA

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

DeSenze Dentistry & Associates

540 East McNab Road Suite E • Pompano Beach, FL 33060 • (954) 785-3210

Cancellation Policy

We understand that unplanned circumstances can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance.

Our doctors and hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no show appointments not cancelled within 24 hours.

AS OF AUGUST 1, 2023, THERE WILL BE A CANCELLTION FEE OF $75 IF WE DO NOT RECEIVE A CALL TO CANCEL AN APPOINTMENT 24 HOURS IN ADVANCE.

Thank you for being a valued patient and for your understanding and cooperation as we enforce this policy.

The staff at Desenze Dentistry and associates

_____ _____

Signature Date

DeSenze Dentistry & Associates

540 East McNab Road Suite E • Pompano Beach, FL 33060 • (954) 785-3210

Financial Policy

Thank you for choosing Dr. Philip S. DeSenze. Our primary mission is to deliver the best and most comprehensive dental care available.

An important part of our mission is making the cost of optimal care as easy and manageable as possible for our patients by offering several payment options.

Please note that payment for all dental treatment is due at the time of service. For treatment requiring several appointments, the total payment due may be divided by the number of appointments need to complete your treatment.

We accept the following forms of payment:

- Cash
- Personal Check through a local bank
- Visa
- Mastercard
- American Express

Financing is also available through Care Credit. This payment plan offers our patients way to pay for the costs of many dental treatments and procedures and allows you to make convenient monthly payments. No interest promotional financing options are available.

For our patients with dental insurance, we will be happy to file your claims for you through your insurance company. All patients are responsible at the time of service for any portion of their care that is not covered by insurance.

Patient (or Legal Guardian) Signature Date Signed

DeSenze Dentistry & Associates

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I, _____, give Philip S. DeSenze, DDS and/or any member of his professional staff, permission to contact me by cell phone, email, home phone and home address to schedule, send reminders to confirm an appointment, to inform me about in-house promotions, and/or to receive important dental information.

☐ Cell Phone: _____

☐ Email Address: _____

☐ Mailing Address (Line 1): _____

☐ Mailing Address (City/State/Zip): _____

☐ Home Phone: _____

Signature: _____

Date Signed: _____

DeSenze Dentistry & Associates

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

Patient Address: _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

If you are the legal representative of the patient, please print the patient's name and describe your authority:

_____

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:

  _____
- ❑ The patient was unable to sign for the following reason:

  _____
- ❑ Other: _____

Prepared By: _____

Signature: _____

Date: _____