COUNTRYSIDE
DENTAL
WE CREATE HEALTHY SMILES

DOMENIC RICCOBONO, D.D.S.
42 Kinderhook Street
Chatham, NY 12037-1207
(518) 392-5231 Phone
www.chathamsmiles.com

Dear Valued Patient,

Welcome and thank you for choosing us to provide your dental care. We are a family oriented practice, offering a wide range of services for both children and adults. We want you to achieve optimal dental health, comfort, function, and appearance. We work in a friendly atmosphere that allows you to feel at home and relaxed.

We would like to get to know you better. Since your dental care affects your general health, and at times your health may affect your dental needs, we ask you to complete the enclosed health questionnaire and patient forms as completely and accurately as possible.

All visits are by appointment. This ensures that we are able to spend enough time with each patient to get the best possible results. Please give us at least 24 hours notice, so we can accommodate another patient. There will be a $50.00 charge for appointments missed or cancelled without notice.

We appreciate you as a patient in our practice and we welcome any questions or concerns you may have about our services and protocols.

And, if you are comfortable in our office, please suggest us to a friend. A referral from you is one of the nicest compliments we could receive.

Sincerely,

Domenic Riccobono, D.D.S.

And the Staff at Countryside Dental

Patient Signature _____ Date _____

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PATIENT INFORMATION

Patient Name: _____ ( ) M ( ) F Birth Date: _____

Address: _____City_____State_____Zip_____ SS#:_____

Phone (Home): _____ Cell: _____ WorK: _____

( ) Married ( ) Single ( ) Child Email address: _____

Responsible Party: Name: _____ ( ) Parent/Guardian ( ) Spouse/Partner ( )Self

Address: _____ Social Security # _____

Birth Date _____ Email address: _____

IF MINOR:

Parent Name: _____ Birth Date: _____

Address: _____ _____

Phone Numbers - Home: _____ Cell: _____ Work: _____

Employer's Name: _____

Parent Name: _____ Birth Date: _____

Address: _____

Phone Numbers – Home: _____ Cell: _____ Work: _____

Employer's Name: _____

DENTAL INSURANCE INFORMATION

Primary Insurance Plan: _____ Employer:_____

Subscriber's Name: _____ Birth Date: _____

ID#: _____ Group#:_____

Secondary Insurance Plan : _____ Employer:_____

Subscriber's Name: _____ Birth Date: __ _____

ID#: _____ Group#: _____

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

ASSIGNMENT OF BENEFITS

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business department. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all dental benefits, to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/dental plan, to issue payment check(s) directly to **COUNTRYSIDE DENTAL, P.C.** for dental services rendered to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **COUNTRYSIDE DENTAL, P.C.** to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested dental services from **COUNTRYSIDE DENTAL, P.C.** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full, immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

I have completed this form fully and completely and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services at the time that they are rendered.

Preferred Method of Payment ( ) Cash ( ) Check ( ) Credit Card ( ) Care Credit

Signature of Patient or Responsible Party _____ Date _____

Whom may we thank for referring you? _____

In Case of Emergency: Name/Relationship Phone # Address

#1 _____ _____ _____

#2 _____ _____ _____

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DENTAL HISTORY

Name _____ DOB _____

How would you rate the condition of your mouth? □ Excellent □ Good □ Fair □ Poor

Previous Dentist _____ How long had you been a patient? _____ Months/Years

Address _____

Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____

I routinely see my dentist every: □ 3 mo. □ 4 mo. □ 6 mo. □ 12 mo. □ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
PERSONAL HISTORY		
1. Are you fearful of dental treatment?	□	□
2. How fearful, on a scale of 1 (least) to 10 (most) _____	□	□
3. Have you had an unfavorable dental experience?	□	□
4. Have you ever had complications from past dental treatment? _____	□	□
5. Have you ever had trouble getting numb or had any reactions to local anesthetic?	□	□
6. Did you ever have braces, orthodontic treatment or had your bite adjusted?	□	□
7. Have you had any teeth removed?	□	□

BITE AND JAW JOINT	**YES**	**NO**
8. Do you have problems with your jaw joint? (pain, sounds, limited opening locking, popping)?	□	□
9. Do you have any problems chewing gum?	□	□
10. Do you have any problems chewing bagels, baguettes, protein bars, or other hard foods?	□	□
11. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	□	□
12. Are you teeth crowding or developing spaces?	□	□

	YES	NO
13. Do you have more than one bite and squeeze to make your teeth fit together?	☐	☐
14. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
15. Do you clench your teeth in the daytime or make them sore?	☐	☐
16. Do you have any problems with sleep, do you wake up with an awareness of your teeth?	☐	☐
17. Do you wear or have you ever worn a bite appliance?	☐	☐

TOOTH STRUCTURE

18. Have you had any cavities within the past 4 years?	☐	☐
19. Do you have a dry mouth or do you have difficulty swallowing any food?	☐	☐
20. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
21. Are you sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
22. Do you have grooves or notches in your teeth near the gum line?	☐	☐
23. Do you have a broken tooth, chipped tooth, or a cracked filling?	☐	☐
24. Do you get food caught between any teeth?	☐	☐

GUM AND BONE

25. Do your gums bleed when brushing or flossing?	☐	☐
26. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
27. Have you ever noticed a persistent, unpleasant taste or odor in your mouth?	☐	☐
28. Is there anyone with a history of periodontal disease in your family?	☐	☐
29. Have you ever experienced gum recession?	☐	☐
30. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
31. Have you experienced a burning sensation in your mouth?	☐	☐

SMILE CHARACTERISTICS

32. Is there anything about the appearance of your teeth that you would like to change?	☐	☐
33. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐	☐
34. Are you interested in improving the appearance of your teeth?	☐	☐

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MEDICAL HEALTH HISTORY

Patient Name _____ DOB _____

Name of Physician/and their specialty_____

Address _____ Phone Number: _____

Additional Doctor _____ Phone Number: _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? □ Excellent □ Good □ Fair □ Poor

Hospitalization for illness or injury (date) _____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment. _____

_____

Has there been any change in your general health within the past year? YES NO

Are you now under the care of a physician? YES NO

If yes, what? _____

If patient is a child: is child taking fluoride vitamins? YES NO

ARE YOU:

Taking medication for weight management (fen-phen)	YES	NO	Taking dietary supplements	YES	NO
Often exhausted or fatigue	YES	NO	FEMALE – pregnant	YES	NO
Often unhappy or depressed	YES	NO	FEMALE – taking birth control pills	YES	NO
A smoker or smoked previously	YES	NO	MALE – prostate disorders	YES	NO

PLEASE ANSWER YES OR NO:

Heart problems, or cardiac stent within the last six months	YES	NO	Contact lenses	YES	NO
Heart attack/Chest Pains	YES	NO	Neurologic problems (attention deficit disorder)	YES	NO
Heart Murmur	YES	NO			
History of infective endocarditis	YES	NO	Epilepsy, convulsions (seizures)	YES	NO
Artificial heart valve, repaired heart defect (PFO)	YES	NO	Viral infections and cold sores	YES	NO
Pacemaker or implantable defibrillator	YES	NO	Any lumps or swelling in the mouth	YES	NO
Artificial prosthesis (heart valve or joints)	YES	NO	Hives, skin rash, hay fever	YES	NO
Rheumatic or scarlet fever	YES	NO	Venereal disease	YES	NO
High or low blood pressure	YES	NO	HIV/AIDS	YES	NO
A stroke (taking blood thinners)	YES	NO	Hepatitis (type _____)	YES	NO
Anemia, blood transfusion, or other blood disorder	YES	NO	Tumor, abnormal growth	YES	NO
Prolonged bleeding due to a slight cut (INR.3.5)	YES	NO	Cancer (type _____)	YES	NO
Emphysema, sarcoldosis	YES	NO	Radiation therapy	YES	NO
Tuberculosis	YES	NO	Chemotherapy	YES	NO
Asthma, hay fever, shortness of breath	YES	NO	Emotional problems	YES	NO
Breathing or sleep problems (I.e. snoring, sinus) sleep apnea	YES	NO	Psychiatric treatment	YES	NO
Kidney disease	YES	NO	Antidepressant medication	YES	NO
Liver disease	YES	NO	Alcohol/drug dependency	YES	NO
Jaundice	YES	NO	Marked weight change	YES	NO
Lyme disease	YES	NO	Night sweats	YES	NO
Thyroid	YES	NO	Persistent fever	YES	NO
Parathyroid disease (kidney stones)	YES	NO	Change in skin color/Jaundice	YES	NO
Calcium deficiencies	YES	NO	Visual Change	YES	NO
Hormone deficiencies	YES	NO	Loss of hearing , dizziness, fainting	YES	NO
High cholesterol or taking statin drugs	YES	NO	Ringing of ears	YES	NO
Diabetes (HbA2c= _____)	YES	NO	Frequent nose bleeds	YES	NO
Stomach or duodenal ulcer	YES	NO	Persistent throat soreness/hoarseness	YES	NO
Digestive disorders (i.e. gastric reflux)	YES	NO	Frequent headaches	YES	NO
Arthritis	YES	NO	Head or neck injuries	YES	NO
Osteoporosis/osteopenia (I.e. taking bisphosphonates)	YES	NO	Bruise easily	YES	NO
Glaucoma	YES	NO	Ulcers	YES	NO

Name _____ DOB _____

DO YOU HAVE or HAVE YOU EVER HAD

1. An allergic reaction to:

☐ Aspirin, ibuprofen, acetaminophen, codeine	☐ Other antibiotics
☐ Penicillin	☐ Other narcotics/barbiturates
☐ Erythromycin	☐ Sedatives/sleeping pills
☐ Tetracycline	☐ Sulfa drugs
☐ Local anesthetic (ex. Novocaine)	☐ Fluoride
☐ Latex	☐ Other _____

*Other allergies including food, metals (nickel,gold,silver), adhesive tape, etc. _____

Are you taking any of the following DRUGS or MEDICATIONS?

Antibiotics	YES	NO	Tranquilizers	YES	NO
Blood thinners	YES	NO	Insulin	YES	NO
Blood Pressure Meds	YES	NO	Diabetic Drug	YES	NO
Thyroid Meds.	YES	NO	Digitalis	YES	NO
Allergy Drugs	YES	NO	Nitroglycerin	YES	NO
Cortisone/Steroids	YES	NO	Heart drugs	YES	NO
Antihistamines	YES	NO	Cold Remedies	YES	NO
Aspirin	YES	NO	Other _____		

*If YES to any of the above, list NAME and DOSAGE of medication: _____

_____

Is there any disease, condition, or problem not listed above that you think we should know about, or is there an activity your doctor says you cannot do? If YES, please explain: _____

_____

To the best of my knowledge, all the preceding answers are correct. If I ever have any change in my health or medication, I will inform Dr. Domenic Riccobono at my next appointment.

Signature of patient, Parent or Guardian _____ Date _____

Dr. Domenic Riccobono, D.D.S. _____ Date _____