John B. DeBonis, D.M.D
467 Lincoln Ave, Pittsburgh PA 15202 (412) 761-9594

Hello _____,

Welcome to the office of Dr. John B. DeBonis.

Thank you for choosing us for your dental health needs. By choosing us you have selected a practice whose doctor has demonstrated the highest level of clinical excellence that you would want in your dentist. Our office has had the privilege of providing outstanding dental care in the Bellevue area and surrounding communities since 1988.

I graduated first in the class of 1987 from the University of Pittsburgh School of Dental Medicine. I am passionate about my family, our patients and our community. I enjoy racquet sports, especially paddle tennis and ping pong.

This will confirm that you are scheduled for your appointment on _____ at _____. **We ask that you please plan to arrive promptly for your check-in time of _____, which is 15 minutes before your scheduled appointment.** This allows us time to obtain any additional details needed prior to your appointment time.

In preparation for your appointment, we ask that you please complete the Welcome Packet included with this letter. This will allow us to maximize your appointment time. **There is also free parking available in the back of our office building, which can be accessed by using Sheridan Avenue, turn at the Pizza Hut sign on Lincoln Ave.** We look forward to meeting you. Welcome to our practice!

Sincerely,

Dr. John B. DeBonis

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Patient Registration

Full Name: _____

Preferred Name: _____

Email Address: _____

Home Address: _____

City: _____ **State:** _____**Zip:** _____

Cell Phone: _____ **Work Phone**: _____

Dob: _____ **SS#:** _____ **Marital Status:** _____

Pharmacy: _____**Phone:** _____

Person Responsible for Account: _____

Emergency Contact: _____ **Phone:** _____

How did you hear about our office? _____

Primary Dental Insurance Coverage

Please be sure to check your insurance is NOT A DMO, DMHO Or HMO Plan

Subscriber Name: _____

Relation to Patient: _____ **SS#:** _____ **D.O.B.:** _____

Employer: _____

Dental Insurance Company: _____

Subscriber #: _____ **Group #:** _____

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Dental History

1. Do you have dental examinations on a routine basis? _____
2. Do you think you have active decay or gum disease? _____
3. Do you brush and floss on a routine basis? _____
4. Do your gums ever bleed? _____
5. Does food catch between your teeth? _____
6. Any loose teeth? _____
7. Do you ever have clicking, popping or discomfort in the jaw joint? _____
8. Do you BRUX or grind your teeth? _____
9. Do you have any sores or growths in your mouth? _____
10. Have your past experiences in a dental office always been positive? _____
11. Are you pregnant? _____
12. Are you nursing? _____
13. Do you smoke or use tobacco? _____
14. Name of previous dentist: _____
15. Do you have a specific dental problem? _____
16. Date of last full mouth x-rays or panorex: _____

Height: _____ Weight: _____

Allergies (Please list all items that may apply)

1. _____ 2. _____ 3. _____

Medications

1. _____2. _____3. _____

4. _____5. _____6. _____

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Medical History

YES	NO		YES	NO	
☐	☐	Abnormal bleeding	☐	☐	Glaucoma
☐	☐	Alcohol/drug abuse	☐	☐	HIV+ Aids
☐	☐	Allergies (Medicines)	☐	☐	Hay fever/allergies
☐	☐	Anemia	☐	☐	Heart murmur
☐	☐	Angina/Chest Pain	☐	☐	Heart pacemaker
☐	☐	Arthritis/Gout	☐	☐	Heart trouble/disease
☐	☐	Artificial heart valve	☐	☐	Hepatitis A, B or C
☐	☐	Artificial joint	☐	☐	High blood pressure
☐	☐	Asthma	☐	☐	High Cholesterol
☐	☐	Blood disorders	☐	☐	Kidney problems
☐	☐	Bruise easily	☐	☐	Liver disease
☐	☐	Cancer-Chemotherapy	☐	☐	Low blood pressure
☐	☐	Congenital heart defect	☐	☐	Mitral valve prolapses
☐	☐	Daily aspirin regimen	☐	☐	Need Premedication?
☐	☐	Diabetes/Hypoglycemia	☐	☐	Osteoporosis/Osteopenia
☐	☐	Difficulty breathing	☐	☐	Radiation therapy
☐	☐	Emphysema/lung disease	☐	☐	Recent weight change
☐	☐	Epilepsy	☐	☐	Rheumatic/scarlet fever
☐	☐	Excessive thirst	☐	☐	Seizures
☐	☐	Fainting or dizziness	☐	☐	Sexually transmitted disease

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HIPAA Acknowledgement

I have received and reviewed a copy of our dental practice's privacy, security and breach notification policies and procedures. I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

Print Name: _____

Signature: _____

Date: _____

Policy Agreement

Appointments: In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. **We require at least 48-hour notice for any cancelled appointment. At the time of any cancellation under 48-hours, we will apply a $50.00 fee.** After 3 missed appointments or cancelled appointments we will place you on a short call list, which means we will phone you when an appointment time becomes available on short notice. This gives you the opportunity to know if your busy schedule has an opening for a dental appointment within the next few hours.

Insurance Information: As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive your maximum allowable benefits. In order to do this, we need your insurance card and/or insurance policy with you on your first visit of every calendar year (your insurance year may not run January – December) All of our doctors will diagnose treatment based on your dental health not your insurance coverage. If your insurance has not paid within 90 days of services rendered, you will need to make full payment to this office and you will be reimbursed when your insurance company pays. After 90 days, the patient is responsible to pursue payment from the insurance company. All current documentation will be provided by mail in order to assist your inquiries. The insured has a better ability to deal with the insurance company and the employer responsible for the policy. Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.

Patient/ Guardian Signature: _____Date: _____