375 East Main Street
East Islip, NY 11730
631-581-5121
www.drforlano.com

Welcome!

Dr. David Forlano
Elevating Your Expectations

1

About You

NAME & ADDRESS

PATIENT'S NAME _____ DATE OF BIRTH _____

WHAT DO YOU PREFER TO BE CALLED? _____

IF PATIENT IS A MINOR, PARENT/GUARDIAN'S NAME _____

RESPONSIBLE PARTY NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

OCCUPATION _____

EMPLOYER _____

CONTACT INFO

CELL PHONE _____

HOME PHONE _____

WORK PHONE _____

Email ADDRESS _____

PREFERRED CONTACT METHOD *(Circle one)* CELL HOME WORK EMAIL

REFERRAL INFO

Our practice has been built on referrals from family and friends. We do not advertise. Your recommendations are appreciated. Who can we thank for referring you to our office?

_____

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2

Insurance Info

PRIMARY DENTAL INSURANCE

MEMBER'S NAME _____ RELATION _____

MEMBER'S SOC SEC NO _____ DATE OF BIRTH _____

EMPLOYER _____

INSURANCE COMPANY _____

INSURANCE COMPANY CLAIM ADDRESS _____

CITY _____ STATE _____ ZIP _____

ID NUMBER _____ POLICY NUMBER _____ GROUP NUMBER _____

SECONDARY DENTAL INSURANCE

MEMBER'S NAME _____ RELATION _____

MEMBER'S SOC SEC NO _____ DATE OF BIRTH _____

EMPLOYER _____

INSURANCE COMPANY _____

INSURANCE COMPANY CLAIM ADDRESS _____

CITY _____ STATE _____ ZIP _____

ID NUMBER _____ POLICY NUMBER _____ GROUP NUMBER _____

MEDICAL INSURANCE

MEMBER'S NAME _____ RELATION _____

MEMBER'S SOC SEC NO _____ DATE OF BIRTH _____

EMPLOYER _____

INSURANCE COMPANY _____

INSURANCE COMPANY CLAIM ADDRESS _____

CITY _____ STATE _____ ZIP _____

POLICY NUMBER _____ GROUP NUMBER _____

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3

Office Policy

FIRST VISIT - COMPREHENSIVE

On your first visit, you will receive a comprehensive examination and X-rays. You will be checked for cavities, periodontitis, malocclusion, oral cancer and TMD. This appointment will take approximately 45 minutes. A cleaning will not be performed on your initial visit. You will be asked to return so the doctor can explain the findings, explain the treatment options, and establish a Comprehensive Treatment Plan based upon your individual needs and preferences.

FIRST VISIT - LIMITED

If your first visit to our office is because of a dental emergency or a problem, we will X-ray, examine and diagnose the localized problem. The doctor will discuss your treatment options. From there, a Limited Treatment Plan can be established. Once this particular dental problem is corrected, we encourage you to return for a comprehensive examination and treatment plan.

PAYMENT POLICY

Payment can be made by cash, check, MasterCard, VISA, American Express, Discover, or Care Credit. We do not "bill." Payments are expected at the time of service. Extended payment plans are available for extended treatment plans. A pre-payment discount is also available.

DENTAL INSURANCE

If you have dental insurance that is assignable to our office, a co-payment is required on your first visit. Please bring proof of insurance. Co-payments will be required on each subsequent visit. Future co-payments will be explained during your Treatment Plan appointment. You will be responsible for any amounts not covered by your insurance carrier. A 1.5% finance charge per month will be applied to balances due past 30 days. Amounts due past 60 days are considered delinquent.

REGARDING PARTICIPATING PLANS

Regarding participating insurance plans, a co-payment may still be necessary each visit. Please realize that some of the services provided may not be covered, or only partially covered. This depends upon your individual policy, deductible, and maximum annual allowance. Our receptionist can help you with any questions.

_____
Print Name

_____ _____
Signature *Date*

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4

Appointment Policy

APPOINTMENT POLICY

- Patients are seen by appointment only
- We require 48 hour notice if an appointment can not be kept
- If an appointment is missed without 48 hours notice, we reiterate our Appointment Policy
- If a second appointment is missed without 48 hours notice, we ask that you find another dentist*

**The doctor-patient relationship will be ended. We will be available for 30 days following the last broken appointment on an emergency basis only. The Suffolk County Dental Society can assist in locating another dentist.*

WE TRULY COUNT ON YOU BEING HERE

We ask that your dental appointments are given top priority on your daily schedule. A great amount of preparation goes into your dental appointment: we sterilize the necessary instruments, we set up the equipment for your particular procedure, we order components and laboratory work, and we often turn away others in need because we are expecting you.

COMMON COURTESY

Appointments broken on short notice are a major inconvenience to all. Our practice is built around great relationships, and we build our relationships around common courtesy. If you can not keep an appointment, please give us 48 hours notice. We can be reached by telephone or email.

Thank you!

_____
Print Name

_____ _____
Signature *Date*

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5

Medical History

PERSONAL INFO

NAME:

DATE OF BIRTH: GENDER: M F

OCCUPATION: MARITAL STATUS: S M D W

GENERAL HEALTH	YES	NO	IDK
Do you have active tuberculosis, a cough persisting more than three weeks, or a cough that produces blood? **If yes, stop and notify the receptionist.**	❑	❑	❑
Are you now under the care of a physician? Physician's name: Physician's address:	❑	❑	❑
Are you in good health?	❑	❑	❑
Has there been any change in your health within the past year? If yes, what condition:	❑	❑	❑
Have you had a serious illness, operation or have been hospitalized in the past 5 years? If yes, what was the illness?	❑	❑	❑
Date of your last physical exam:			
List your medications:			

RISK OF OSTEONECROSIS OF THE JAW	YES	NO	IDK
Are you taking, ever took, or scheduled to take alendronate (Fosomax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	❑	❑	❑
Date treatment began:			
Since 2001, were you treated, or are you presently scheduled to begin treatment with the IV bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer?	❑	❑	❑
Date treatment began:			

ANTIOBIOTIC PROPHYLAXIS	YES	NO	IDK
Have you had any joint replacements?	❑	❑	❑
Artificial heart valve?	❑	❑	❑
Previous infective endocarditis?	❑	❑	❑
Damaged valves in a transplanted heart?	❑	❑	❑
Congenital heart disease (CHD)?	❑	❑	❑
Unrepaired, cyanotic CHD?	❑	❑	❑
Repaired in last 6 months?	❑	❑	❑
Repaired CHD with residual defects?	❑	❑	❑
Has a physician or dentist ever told you to pre-medicate with antibiotics before dental treatment?	❑	❑	❑

ALLERGIES	YES	NO	IDK
Local anesthetics	❑	❑	❑
Aspirin	❑	❑	❑
Penicillin or other antibiotics	❑	❑	❑
Barbiturates	❑	❑	❑
Sulfa drugs	❑	❑	❑
Codeine or other narcotics	❑	❑	❑
Metals	❑	❑	❑
Latex	❑	❑	❑
Iodine	❑	❑	❑
Hay fever or seasonal allergies	❑	❑	❑
Animals	❑	❑	❑
Food	❑	❑	❑
Other	❑	❑	❑

LIFESTYLE	YES	NO	IDK
Do you wear contact lenses?	❑	❑	❑
Do you use controlled substances or drugs?	❑	❑	❑
Do you use tobacco? (smoking, snuff, chew, bidis)	❑	❑	❑
Do you drink alcoholic beverages? If yes, how much in the last 24 hours? If yes, how much in a typical week?	❑	❑	❑

WOMEN ONLY	YES	NO	IDK
Are you pregnant? If yes, number of weeks:	❑	❑	❑
Are you taking birth control pills?	❑	❑	❑
Are you nursing?	❑	❑	❑

DISEASES	YES	NO	IDK
Cardiovascular disease	❑	❑	❑
Angina	❑	❑	❑
Chest pain upon exertion	❑	❑	❑
Arteriosclerosis	❑	❑	❑
Congestive heart failure	❑	❑	❑
Damaged heart valves	❑	❑	❑
Heart attack	❑	❑	❑
Heart murmur	❑	❑	❑
Low blood pressure	❑	❑	❑
High blood pressure	❑	❑	❑
Mitral valve prolapse	❑	❑	❑
Pacemaker	❑	❑	❑
Rheumatic fever	❑	❑	❑
Rheumatic heart disease	❑	❑	❑
Abnormal bleeding	❑	❑	❑
Anemia	❑	❑	❑
Blood transfusion If yes, date:	❑	❑	❑
Arthritis	❑	❑	❑
Autoimmune disease	❑	❑	❑
Rheumatoid arthritis	❑	❑	❑
Systemic lupus	❑	❑	❑
Asthma	❑	❑	❑
Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
Sinus trouble	❑	❑	❑
Cancer/Chemo/Radiation	❑	❑	❑

	YES	NO	IDK
Chronic pain	❑	❑	❑
Diabetes Type I, Insulin dependent Type II	❑ ❑	❑ ❑	❑ ❑
Eating disorder	❑	❑	❑
Malnutrition	❑	❑	❑
Gastrointestinal disease	❑	❑	❑
GE reflux	❑	❑	❑
Ulcers	❑	❑	❑
Thyroid problems	❑	❑	❑
Stroke	❑	❑	❑
Glaucoma	❑	❑	❑
Hepatitis, jaundice, liver disease	❑	❑	❑
Epilepsy	❑	❑	❑
Fainting or seizures	❑	❑	❑
Neurological disorder If yes, explain:	❑	❑	❑
Sleep disorder	❑	❑	❑
Recurrent infections	❑	❑	❑
Kidney trouble	❑	❑	❑
Night sweats	❑	❑	❑
Osteoporosis	❑	❑	❑
Persistent swollen glands	❑	❑	❑
Migraines	❑	❑	❑
Rapid weight loss	❑	❑	❑
Sexually transmitted disease	❑	❑	❑
Excessive urination	❑	❑	❑
Other	❑	❑	❑

_____ _____
Patient Signature *Date*

_____ _____
Doctor's Signature *Date*


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