



CHRISTOPHER J. MANDUZZI  
— DDS, PC —

7811 Summers St. Utica, MI, 48317 – (586)731-9240 – drmanduzzi.com

**Patient Information \*\*Please Print\*\***

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_ Wk #: \_\_\_\_\_

Email: \_\_\_\_\_

SSN: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Insurance Information:**

Employer: \_\_\_\_\_ Ins Company Name: \_\_\_\_\_

SSN/ID#: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

**Notice of Privacy Practices / Patient Acknowledgement**

I have received this practices' notice of privacy practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practices' legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its notice of privacy practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practices' current Notice of Privacy Practices on request.

I hereby understand that I am financially responsible for all charges, whether or not paid by my insurance and for all services rendered on my behalf or my dependents. I authorize Dr. Manduzzi and/or any supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I hereby authorize payment directly to Dr. Manduzzi for all insurance benefits otherwise payable to me for services rendered. In the event there are over-due balances for which I am responsible, I promise to pay 1.5% per month late fee (18% per Annum), along with actual collection agency and/or attorney fees and court costs.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient: (if signed by a personal representative of patient) \_\_\_\_\_

**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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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



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## **RECORDS RELEASE**

TO:

FAX:

FROM: Christopher J. Manduzzi DDS, PC

FAX: 586-731-4688

PHONE: 586-731-9240

DATE: \_\_\_\_\_

SUBJECT: Request for Patient X-Rays

Patient: \_\_\_\_\_

DOB: \_\_\_\_\_

I \_\_\_\_\_ authorize the release of my x-rays to Christopher Manduzzi DDS, PC.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Please email x-rays to: cmandudds@gmail.com.

Thank you!



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### **Christopher J. Manduzzi, D.D.S., P.C. Cancellation/Missed Appointment Policy**

If you've been a patient in our practice for some time, you know that Dr. Manduzzi puts his heart and soul into caring for his patients and gives his practice his "all" every day, as does the rest of the team. In return, we appreciate and value those patients who consistently respect our time and the effort we put forth by **keeping their appointments**. Every appointment is extremely valuable. Please remember that in scheduling an appointment, we are reserving that time specifically for **you**. There is a significant amount of work done on our end in preparation for every single appointment – reviewing x-rays and chart notes, insurance verification, etc. Taking all of this into account, we hope that you can more easily appreciate why we don't have a high tolerance for missed appointments or short-notice cancellations.

When you miss an appointment, everybody loses. You lose out on the necessary dental care that you purposely scheduled an appointment for, other patients lose out on the availability of that day and time to come in, and our office loses out by having an empty schedule, while incurring virtually the same expenses as if you had come. Therefore, it is the policy of our practice that we require a **48-business-hour notice** to cancel or reschedule an appointment to give us ample time to schedule another patient in that spot.

\*Please note the verbiage of "*business hours*" in this policy – that means calling to cancel on Saturday for Monday still does not help us if we are not in the office.

**We truly do everything we can to make sure our patients know when their appointments are.** We understand that many of our patients lead busy lives which is why we offer text message and e-mail reminders that you simply need to reply "C" to in order to confirm with us that you will be at your appointment. **Confirming your appointments is very important to us.**

Failure to comply with this policy will result in a **\$50 cancellation fee** being automatically billed to your account. Now, we realize that once in a great while, an unforeseen circumstance may arise where a 48-business-hour notice may not be possible. In these instances, please give us as much notice as you possibly can and we will do our best to work with you. That being said, we expect that these instances would be exceedingly rare.

If, in spite of multiple attempts to reach you, you **fail to confirm your appointment within 24 hours** of your scheduled appointment time, we reserve the right to schedule another patient in your place.

Patients who establish a pattern of missing appointments or cancelling with short notice will be **dismissed** from the practice.

#### **Summary**

1. **Confirm your appointments by replying "C" to your appointment reminder text messages.**
2. **Failure to provide 48-business-hours' notice to cancel or reschedule your appointment will result in a \$50 cancellation fee.**
3. **Failure to confirm within 24 hours of your appointment may result in us scheduling another patient in your place.**
4. **Frequently missing appointments or canceling with short notice will result in dismissal from our practice.**

**By signing below, I acknowledge that I understand this policy and agree to the terms described above.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



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**HIPAA Medical/Dental Information Disclosure Consent for  
Spouse/Family/Caregiver/Guardian**

I, \_\_\_\_\_, authorize Dr. Manduzzi and his staff to share or explain aspects of my dental health, concerns, and/or needs to the people I list below.

This explanation may involve details regarding my medical history to properly discuss treatment options. I understand that it is my responsibility to inform Dr. Manduzzi and his staff in the event that I desire to change this list.

Person #1: \_\_\_\_\_ Relationship \_\_\_\_\_

Person #2: \_\_\_\_\_ Relationship \_\_\_\_\_

Person #3: \_\_\_\_\_ Relationship \_\_\_\_\_

Person #4: \_\_\_\_\_ Relationship \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_



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### Sleep Questionnaire

**Please check all that apply**

	Yes	No
Have you ever been told that you snore loudly?	_____	_____
Do you often feel tired, fatigued, or sleepy during the day?	_____	_____
Has anyone observed you stop breathing during your sleep?	_____	_____
Do you clench and/or grind your teeth?	_____	_____
Do you have frequent headaches?	_____	_____
Do you have high blood pressure?	_____	_____
Body Mass Index >30 (lbs x 730/ height in inches (2))?	_____	_____
Age > 50 years old?	_____	_____
Neck Measurement > 16"?	_____	_____
Gender: Male?	_____	_____
Do you wear a CPAP?	_____	_____
Ever had a sleep study done?	_____	_____

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_