nutraDentist

Dr. Mark Buzzatto, DDS, IBDM, NMD, CCWFN

Date: _____

Patient Information

_____ Social Security #: _____

Last Name First Name Initial

Email: _____ Home Phone: _____ Cell: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Age: _____ Birthdate: _____ ☐ Single ☐ Married _____ no. Children

Whom may we thank for referring you? _____

Occupation: _____

In case of emergency, who should be notified? _____ Phone: _____

Dental Insurance

Person Responsible for Account: _____

Last Name First Name Initial

Relation to Patient: _____ Birthdate: _____ Social Security #: _____

Address (if different from patient's): _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Insurance Company: _____

Group Number: _____ Subscriber Number: _____

Insurance Phone: _____ Insurance Claims Address: _____

Pharmacy: _____ Pharmacy Phone: _____

2555 Washington Road, STE 620
Upper St. Clair, PA 15241

412-831-9700

nutradentist@gmail.com

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Medical History Informaiton

Do you have any CURRENT HEALTH PROBLEMS?	Yes	No
Are you under a PHYSICIANS care now?	Yes	No
If yes, for what? _____		
Are you currently taking any medication?	Yes	No
If yes, what? _____		
Are you pregnant?	Yes	No
Do you smoke?	Yes	No

Family Physician's Name _____ Phone: _____

Circle any of the following which you have had or have at present

Heart Attack	Heart Disease	Angina Pectoris
High Blood Pressure	Heart Murmur	Rheumatic Fever
Congenital Heart Lesions	Scarlet Fever	Artificial Heart Valve
Heart Pacemaker	Heart Surgery	Artificial Joint/Hip/Knee
Anemia	Stroke	Kidney Trouble
Ulcers	Cosmetic Surgery	Hepatitis A (infectious)
Hepatitis B (serum)	Liver Disease	Yellow Jaundice
Blood Transfusion	Drug Addiction	Hemophilia
Fever Blisters	Epilepsy or Seizures	Fainting or Dizzy Spells
Nervousness	Psychiatric Treatment	Sickle Cell Disease
Glaucoma	Chemotherapy (Cancer/Leukemia)	Venereal Disease (Syphilis, Gonorrhea, etc.)
Tuberculosis (TB)	Asthma	Hay Fever
Sinus Trouble	Allergies or Hives	Diabetes
Thyroid Disease	X-Ray/Cobalt Treatment	Arthritis
Rheumatism	Cortisone Medication	Pain in Jaw Joints
Alcoholism	Bleeding Problems	Pneumonia
Bruise Easily	Emphysema	

Medical Alerts

Allergic to Aspirin	Allergic to Penicillin	Pre-medication Required
Allergic to Codeine	HIV Positive	
M.V.P.	Prior Hepatitis	
Heart Problems	Other: _____	

Additional Comments: _____

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Dental History Informaiton

Previous Dentist Name: _____ City: _____ Phone: _____

How LONG SINCE you have seen a dentist? _____

Last COMPLETE dental exam date: _____ Last FULL MOUTH X-RAYS date: _____

Are you having PROBLEMS now?	Yes	No
Do you wear DENTURES? (Partials or Full)	Yes	No
Do you have any MISSING teeth other than wisdom teeth?	Yes	No
Have you any PERIODONTAL (GUM) treatments?	Yes	No
Do your gums BLEED, or feel TENDER, or IRRITATED?	Yes	No
Are your teeth SENSITIVE to hot, cold, sweets, or pressure?	Yes	No
Are you UNHAPPY with the appearance of your teeth?	Yes	No
Are you aware of GRINDING or CLENCHING your teeth?	Yes	No
Do you have HEADACHES, EARACHES, or NECK PAINS?	Yes	No
Do you have LOOSE, TIPPED or SHIFTING teeth? (Circle)	Yes	No
Have you worn BRACES on your teeth? (ORTHODONTICS)	Yes	No
Do you have DISCOLORED teeth that bother you?	Yes	No
Would you like your smile to LOOK BETTER or DIFFERENT?	Yes	No
Do you have problems with teeth/fillings BREAKING?	Yes	No
Do you REGULARLY use DENTAL FLOSS?	Yes	No
Are you aware of being ALLERGIC TO or reacting adversely to any medications or substances?	Yes	No

If yes, please list:

_____

_____

Important: *If you have had x-rays taken within the last two years, please contact your previous dentist to have them sent to nutradentist@gmail.com. Patient x-rays must be here before your appointment otherwise new x-rays will need to be taken. Please make sure that the date the x-rays were taken is included.*

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Name: _____ Date: _____

Dental health has a direct effect on physical health. The state of our health has a direct effect on quality of life. In many cases a dentist, especially one who is trained in the holistic arts, can identify if an illness may be forming in the body before any symptoms appear. *nutra*Dentist has several adjunct examinations designed for such identification.

Examination	Very Interested	Need More Information	Not For Me
1. Safe Amalgam Removal	☐	☐	☐
Safely removes mercury amalgam fillings from the teeth to significantly lower mercury exposure.			
2. **Hair Mineral Analysis	☐	☐	☐
Reveals nutritional deficiencies and metabolic dysfunction.			
3. **Nutrition Exam	☐	☐	☐
Identifies any nutritional gaps that may cause the immune system to become suppressed before symptoms may manifest.			
4. **Supplementation	☐	☐	☐
Supplementation aids in a strong foundation for oral health as well as the overall health.			
5. Whitening	☐	☐	☐
A bright white smile doesn't necessarily contribute to health but does give you a boost of confidence! Venus Whitening, uses natural ingredients designed to whiten the teeth without sensitivity.			

These exams along with the Comprehensive Exam and a complimentary box of whole food supplements are included in the **WOW exam.

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Financial Policy

Thank you for choosing our office for your dental and/or nutritional needs. We are committed to providing the highest quality care available to our patients and to make those services comfortably affordable.

The following is an assessment of our financial Policy which must be reviewed and signed.

Insurance:
As a courtesy, our office will submit your claims to your insurance carrier so you don't have the burden of filling out the forms necessary to get your reimbursement. Our patients generally receive payment from their insurance carriers within 3 – 4 weeks. We are out-of-network providers and therefore have no connection to your insurance plan. Your insurance coverage is a contract between you and insurance company.

If you have any questions about your reimbursement or estimate of benefits please contact your insurance company directly.

All payments are due when services are rendered.

Payment Options: Check or Cash (discount provided)
Visa, MasterCard, and Discover
Care Credit – Same as Cash option available for qualifying purchases

_____ *Initial* **Missed Appointments:** We require at least **24 hours cancellation notice** for all appointments. Our policy is to charge a **$50.00 fee** for all appointments cancelled within the 24 hour time period. We have reserved the doctor's time just for you. Please help us serve you better by keeping your appointments and being on time.

Returned Checks: There will be a $35.00 fee charged for all returned checks

Unpaid Balances:
Any account that is unpaid without a payment established and timely payments made will be turned over to a collection agency. We strive to work with our patients to provide excellent service. Please pay your bill on time. Thank you for understanding our Financial Policy.
We are here to assist you in any way possible. Please make your questions and concerns known to our team as our goal is to ensure that you have an exceptional experience at our office.

I have read the Financial Policy and I understand and agree to the terms. I agree that I am financially responsible for all services rendered to the patient.

Print Responsible Party Name: _____ Date: _____

Signature of Responsible Party: _____

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Nutritional Informed Consent

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG"is defined to mean:

"Articles intended for use in the Diagnoses, Cure, Mitigation, Treatment or Prevention of disease"

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid or Herb may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented or be classified as a drug by anyone.

Therefore please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical process of the human body.

I, _____ have read and understand the above.
(Print Name)

Signature: _____ Date: _____

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THE NUTRITIONAL BALANCING ACADEMY (A Private Membership Group) MEMBERSHIP AGREEMENT

EXPLANATION. This form should not be needed. However, medical licensing boards sometimes harass those receiving holistic health information. The goal of the private member group is to protect all of us from such harassment.

_____ hereby applies for membership in the NUTRITIONAL BALANCING ACADEMY, hereinafter referred to as the "Academy" - a private membership association. With the signing of this agreement I accept the offer made to become a member and I express my agreement with the following *Declaration* and *Memorandum Of Understanding*:

DECLARATION

1. This association of members hereby declares that our primary purpose is to maintain and protect our right as US citizens to freedom of choice in matters of our health care. This includes: a) the therapies and modalities we use, b) when and how we use them, c) where we use them, d) why we use them, and e) who administers them.
2. As members, we affirm our belief that the Constitution of the United States guarantees all Americans, particularly members of private associations, the right of freedom of association, speech, assembly, belief, and associated activities. These are our inalienable rights.
3. We claim our freedom to choose and accept for ourselves the types of health care modalities that we think are best. We reserve the right to include traditional, non-traditional or even unconventional health care options.
4. We further declare and assert the right to select whomever can be expected to give us the wisest counsel and advice, regardless of their training or licensing status.

We assert these rights under the United States national and state constitutions, national and state laws, and the regulations interpreting them.

MEMORANDUM OF UNDERSTANDING

1. I understand that members of the Academy that provide services or advice do so in the capacity of fellow members in a private manner and not in the capacity as public healthcare providers. Thus, within the Academy, no public doctor-patient or public therapist-client relationship exists.
2. I freely choose to change my legal status from that of a pub1ic healthcare recipient to that of a private membership association member.
3. I understand that I am joining this private membership group under the common law and the First Amendment of the US Constitution – the right to associate freely.
4. I understand that members seek to help each other achieve and sustain better health.
5. I accept that the facilitators and other healthcare providers, who are fellow members, offer advice, services, and benefits that are not necessarily conventional or traditional.
6. I understand that it is my personal responsibility to evaluate the services offered and to educate myself as to their efficacy, risks, or desirability. I agree that the actions I take, in this regard, are of my own free-will. Thus, I agree to hold harmless the Academy and member-facilitators from any unintentional liability that might result from the advice or services I receive, except for the harm that could remotely result from an instance of "a clear and present danger of substantive evil" - as determined by the Academy and as defined by the United States Supreme Court.
7. Thus, I agree not to file malpractice, civil or criminal lawsuits against a fellow member, unless that member exposes me to a clear and present danger of substantive evil.
8. I agree that all Academy members are exempt from the provisions of any state Medical Practices Act, Federal Food Safety Modernization Acts, Codex Alimentarius or any similar federal or state legislation designed to "protect the public".
9. I understand that, since the Academy is protected by the First, Ninth and Fourteenth Amendments to the United States Constitution, it is exempt from any action of Federal and State agencies entrusted to "protect the public" – as it relates to any complaints or grievances against the Academy, its physical premises or equipment, its officers, board of directors, Helpers, Coaches or other associated staff or consultants. All complaints or grievances will be settled by non-judicial mediation or binding arbitration within the Academy.
10. Private member records kept by the Academy are strictly private and can only be released upon written request of the subject member. The only exception is if records are subpoenaed by a warrant duly signed and specific as to date and content.
11. I realize that no health screening, resulting conclusions or health care services are foolproof. For example, if I choose to forego drugs, surgery or treatments that have been recommended by others, in the public sector, I accept that risk. I assert my right of informed consent.
12. I enter into this agreement of my own free will, or on behalf of a designated dependent, without any pressure or promise of benefit.
13. I affirm that I do not represent any state or federal agency whose purpose is to regulate the practice of medicine or any other health care system.
14. I accept that membership does not entitle me to any voting interest in the Academy. I also acknowledge I am not liable for any debts, liabilities, suits or judgments against the Academy.
15. This document consists of my entire agreement for membership and it supersedes any previous agreement I may have made.
16. I understand that $10.00 of my initial consultation fee is for consideration for my membership, and *this fee has been waived by the Academy*.
17. The term of membership begins with the date of the acceptance of this agreement and continues until the dissolution of this Academy or until termination of membership by the Academy if I should violate the rules herein.

Print Applicant's Name: _____

Applicant's Signature: _____

Accepted by _____ Date_____

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HIPAA Privacy Authorization Form

** Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

I_____ hereby authorize NUTRADENTIST,LLC and its affiliates and employees to release to any dental insurance and/or referring dental professionals, my personal health information maintained by nutraDentist, LLC (e.g. information relating to the diagnoses, treatment, claims payment and healthcare services provided or to be provided to me and which identifies my name, address, social security number, Member ID number for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of N/A. I understand that I have a right to revoke this authorization by providing written notice to nutraDentist, LLC. However this authorization may not be revoked if nutraDentist, LLC its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Patient_____

Signature of Patient/Guarantor_____

Date_____

If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the member identified above and will provide written proof (e.g. Power of Attorney, Living Will, guardianship papers etc.) that I am legally authorized to act on the Members behalf with respect to this authorization form.

Name of Legal Representative_____

Signature of Legal Reprensentative_____

Date:_____

Name if Witness_____

Signature of Witness_____

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