(PLEASE PRINT)

## Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

## Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

## Phone Numbers

Home (_____) _____ Work (_____) _____ Ext _____ Alt. Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name _____ Relationship _____

Phone (_____) _____ Alt. Phone (_____) _____

## Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Bad breath | ☐ Yes | ☐ No | Burning sensation on tongue | ☐ Yes | ☐ No | Mouth breathing | ☐ Yes ☐ No |
| Bleeding gums | ☐ Yes | ☐ No | Chew on one side of mouth | ☐ Yes | ☐ No | Mouth pain, brushing | ☐ Yes ☐ No |
| Blisters on lips or mouth | ☐ Yes | ☐ No | Cigarette, pipe, or cigar smoking | ☐ Yes | ☐ No | Orthodontic treatment | ☐ Yes ☐ No |
| | | | Clicking or popping jaw | ☐ Yes | ☐ No | Pain around ear | ☐ Yes ☐ No |
| | | | Dry mouth | ☐ Yes | ☐ No | Periodontal treatment | ☐ Yes ☐ No |
| | | | Fingernail biting | ☐ Yes | ☐ No | Sensitivity to cold | ☐ Yes ☐ No |
| | | | Food collection between the teeth | ☐ Yes | ☐ No | Sensitivity to heat | ☐ Yes ☐ No |
| | | | Foreign objects | ☐ Yes | ☐ No | Sensitivity to sweets | ☐ Yes ☐ No |
| | | | Grinding teeth | ☐ Yes | ☐ No | Sensitivity when biting | ☐ Yes ☐ No |
| | | | Gums swollen or tender | ☐ Yes | ☐ No | Sores or growths in your mouth | ☐ Yes ☐ No |
| | | | Jaw pain or tiredness | ☐ Yes | ☐ No | | |
| | | | Lip or cheek biting | ☐ Yes | ☐ No | How often do you floss? _____ | |
| | | | Loose teeth or broken fillings | ☐ Yes | ☐ No | How often do you brush? _____ | |

# Dental Registration and History

## Health History

Physician's Name _____ Date of last visit_____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ☐ Yes | ☐ No | Epilepsy | ☐ Yes | ☐ No | Respiratory Disease | ☐ Yes | ☐ No |
| Anemia | ☐ Yes | ☐ No | Fainting or dizziness | ☐ Yes | ☐ No | Rheumatic Fever | ☐ Yes | ☐ No |
| Arthritis, Rheumatism | ☐ Yes | ☐ No | Glaucoma | ☐ Yes | ☐ No | Scarlet Fever | ☐ Yes | ☐ No |
| Artificial Heart Valves | ☐ Yes | ☐ No | Headaches | ☐ Yes | ☐ No | Shortness of Breath | ☐ Yes | ☐ No |
| Artificial Joints | ☐ Yes | ☐ No | Heart Murmur | ☐ Yes | ☐ No | Sinus Trouble | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No | Heart Problems | ☐ Yes | ☐ No | Skin Rash | ☐ Yes | ☐ No |
| Back Problems | ☐ Yes | ☐ No | Hepatitis Type _____ | ☐ Yes | ☐ No | Special Diet | ☐ Yes | ☐ No |
| Bleeding abnormally, with extractions or surgery | ☐ Yes | ☐ No | Herpes | ☐ Yes | ☐ No | Stroke | ☐ Yes | ☐ No |
| Blood Disease | ☐ Yes | ☐ No | High Blood Pressure | ☐ Yes | ☐ No | Swollen Feet or Ankles | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No | Jaundice | ☐ Yes | ☐ No | Swollen Neck Glands | ☐ Yes | ☐ No |
| Chemical Dependency | ☐ Yes | ☐ No | Jaw Pain | ☐ Yes | ☐ No | Thyroid Problems | ☐ Yes | ☐ No |
| Chemotherapy | ☐ Yes | ☐ No | Kidney Disease | ☐ Yes | ☐ No | Tonsillitis | ☐ Yes | ☐ No |
| Circulatory Problems | ☐ Yes | ☐ No | Liver Disease | ☐ Yes | ☐ No | Tuberculosis | ☐ Yes | ☐ No |
| Congenital Heart Lesions | ☐ Yes | ☐ No | Low Blood Pressure | ☐ Yes | ☐ No | Tumor or growth on head or neck | ☐ Yes | ☐ No |
| Cortisone Treatments | ☐ Yes | ☐ No | Mitral Valve Prolapse | ☐ Yes | ☐ No | Ulcer | ☐ Yes | ☐ No |
| Cough, persistent or bloody | ☐ Yes | ☐ No | Nervous Problems | ☐ Yes | ☐ No | Venereal Disease | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No | Pacemaker | ☐ Yes | ☐ No | Weight Loss, unexplained | ☐ Yes | ☐ No |
| Emphysema | ☐ Yes | ☐ No | Psychiatric Care | ☐ Yes | ☐ No | | | |
| Do you wear contact lenses? | ☐ Yes | ☐ No | Radiation Treatment | ☐ Yes | ☐ No | | | |

**Women:**

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

## Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

## Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

## Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what?_____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

# Our Financial Policy

Thank you for choosing us for your dental needs. We are committed to providing you, our patient with exceptional state of the art dental care based on your individuals needs. Our financial arrangement is based on an open and honest discussion of recommended treatment options, respective fee and patient's financial capabilities. Please read the following information and sign.

## Payment

Payment is due at the time of service unless prior financial arrangements are made. We accept Cash, American Express, Visa, Master card, Discover and additional payment plans such as Wellsfargo, Carecredit, Lendingclub and more. Payment for services for treatment of minors is the responsibility of the adult accompanying that minor.

## Insurance

Our office is committed to helping our patients maximize their benefits. Insurance policies vary greatly, every effort is made to accurately estimate your coverage but we cannot guarantee coverage due to the complexities of the insurance contracts. Dental insurance is a contract between the insurance company and the patient, not the dentist. Patients are responsible for all cost not paid by their insurance. If you have any questions, our courteous staff is available to answer them.

## Missed Appointments

We are able to provide the highest quality of care to our patients by assigning each patient a specific time for treatment rendered. Please make sure you make your appointment at a time you are able to come in.

If you need to reschedule your appointment for any reason, our policy is to charge for missed appointments that are not cancelled at least 48 hours in advance. The charge is $75. Please help us serve you better by being on time and keeping your appointment.

## Collection Fees

All fees must be paid within 60 days from the date of treatment. Any agency fees incurred to collect outstanding balance will be billed to and payable by the account holder.

Financial consent

The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office.

I understand and agree to this Financial Policy and Agreement

_____ _____

Signature of Patient/ Responsible Party Date

# Patient Health History

**OBJECTIVE** **In an effort to access your medical benefits and gain the maximum reimbursement for you, we need your assessment and details of your physical and mental health. This information will be used to gain the proper authorization for your procedures. Please be detailed in your responses.**

**PERSONAL HISTORY** Please tell us your main concern and what you feel has lead you to the condition you are in now. And, how long you have been in your present condition.

_____

_____

_____

_____

**MEDICAL HISTORY** List drugs prescribed and over-the-counter that you have taken on a daily basis.

_____

_____

_____

_____

_____

Past and recent surgeries / procedures

_____

_____

_____

_____

**FUNCTION** How has this condition affected your ability to function and your health?

_____

_____

_____

_____

**DIAGNOSIS** Have you been or are you presently diagnosed and being treated with any condition that has affected your physical and mental health?

_____

_____

_____

_____

_____

**AUTHORIZATION** I consent to allow the office to share this medical information with the insurance company to help support the medical necessity for my procedures.

Patient Name Printed: _____

Patient Signature: _____

Date: _____

**BROOKLYN DENTAL**
**ADVANCE DENTAL CARE OF NYC**
142 Joralemon Street, Suite 6E
Brooklyn, NY 11201
(718)624-1970

# Notice of Privacy Practices
# Patient Acknowledgement

Patient Name: _____

Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the use 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 practice's 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, controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____

Date: _____

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

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Acknowledgement of Receipt of HIPAA Privacy Policies

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office, and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purpose, payment activities, and healthcare operations of the office as described in the Notice.

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Print Name of Patient or Personal Representative (Including description of legal authority)

---

Signature of Patient or Personal Representative

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Date

| FOR OFFICE USE ONLY |
|---|

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__Individual refused to sign

__Communication barriers prohibited obtaining the acknowledgement

__An emergency situation prevented us from obtaining acknowledgement

__Other (Please Specify)

# Medical Information Release

Your Signature is necessary for us to:

- PROCESS ALL INSURANCE CLAIMS
- ENSURE PAYMENT FOR SERVICES RENDERED
- RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS
- RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES WHEN NECESSARY FOR YOUR TREATMENT.
- PROVIDE EXCELLENT DIAGNOSTIC AND PREVENTIVE CARE

I hereby authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits, to which I am entitled to Dr. _____. This assignment will remain in effect until revoked by me in writing. Photocopy of this assignment to be considered as valid as the original.

Patient Name Printed: _____

Patient or Guardian Signature: _____

Date: _____