Welcome

Thank you for your visit. We appreciate you trusting us to care for your dental health, and pleased to welcome you to our practice. To help us serve you better, please take a few moments to fill out the following forms as completely as you can. If you have any questions, just ask, we will be glad to help. We look forward to working with you!

Patient Information

Name _____ Social Security # _____

Address _____ City _____ State ____ ZIP _____

Home Phone _____ Cell phone _____

e-mail _____ Sex □ Male □ Female Age _____ Birthdate _____

Marital Status □ Single □ Married □ Widowed □ Divorced □ Separated

Business address _____ Work phone _____

Whom may we thank for referring you? _____

Whom may we notify in case of emergency? _____ Phone _____

Primary Insurance

Member Name _____

Relation to patient _____ Birth date _____ Social Security # _____

Address (If different from pt.) _____ Phone _____

City _____ State _____ ZIP _____

Employed by _____ Occupation _____

Business address _____ Work phone _____

Insurance Company _____

Contract # _____ Group _____ Subscriber # _____

Dental History

Reason for today's visit _____

Previous dentist _____ Address _____

Date of last dental visit _____ Last dental x rays _____

Please check if you have had any of the following:

□ Bad breath
□ Bleeding gums
□ Clicking or popping jaw
□ Food collects between teeth
□ Grinding teeth
□ Loose teeth or broken fillings
□ Periodontal treatment
□ Sensitivity to cold
□ Sensitivity to heat
□ Sensitivity to sweets
□ Sensitivity when biting
□ Sores or growths in the mouth

How often do you floss? _____

Are you happy with your smile? **YES / NO** If **NO**, explain: _____ _____

Medical History

Physician's name _____

Previous hospitalizations, illnesses, or operations (please describe, and give approximate date) _____

_____

Have you ever had a blood transfusion? ☐ **Yes** ☐ **No** If yes, please give approximate date _____

Are you pregnant? ☐ **Yes** ☐ **No** Are you nursing? ☐ **Yes** ☐ **No** Taking birth control pills? ☐ **Yes** ☐ **No**

Do you snore? ☐ **Yes** ☐ **No** Has anyone ever told you that you snore? ☐ **Yes** ☐ **No**

How often do you doze off or fall asleep while sitting, reading or watching TV:

☐ **Never** ☐ **Sometimes** ☐ **Always**

Please check if you have or have had any of the following:

☐ AIDS	☐ Cortisone Treatments	☐ High Blood Pressure	☐ Scarlet Fever
☐ Anemia	☐ Cough, Persistent	☐ HIV Positive	☐ Shortness of Breath
☐ Arthritis, Rheumatism	☐ Cough up Blood	☐ Jaw Pain	☐ Sleep Apnea
☐ Artificial Heart Valves	☐ Diabetes	☐ Kidney Disease	☐ Skin Rash
☐ Artificial Joints	☐ Epilepsy	☐ Liver Disease	☐ Stroke
☐ Asthma	☐ Fainting	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Back Problems	☐ Glaucoma	☐ Nervous Problems	☐ Tobacco Habit
☐ Blood Disease	☐ Heart Murmur	☐ Pacemaker	☐ Tonsillitis
☐ Cancer	☐ Heart Problems	☐ Psychiatric Care	☐ Tuberculosis
☐ Chemical Dependency	☐ Describe: _____	☐ Radiation Treatment	☐ Ulcer
☐ Chemotherapy	☐ Hemophilia	☐ Respiratory Disease	☐ Venereal Disease
☐ Circulatory Problems	☐ Hepatitis	☐ Rheumatic Fever	☐ Other

If you have been diagnosed with Sleep Apnea, are you on **CPAP**? ☐ **Yes** ☐ **No**

Please list any medications you are currently taking _____

Do you suffer from frequent headaches? _____

Please list any allergies _____

Authorizations

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided, will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any change in my health status should occur.

I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all insurance submissions.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf. I understand that if I want to get an estimate of my insurance coverage I may request a pre authorization of services.

I understand that notice at least 24 hours prior to your appointment is required for any cancellations with a general dentist. I also understand that notice at least 48 hours prior to the appointment will be required when scheduled with one of the specialists.

I understand that I will be charged a fee for any appointment cancelled or rescheduled within 24 hours.

Signature _____ **Date** _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

***Purpose of consent**:*

By signing this you will consent to our use and disclosure of your protected health information to carry out treatment payment activities and health care operations.

Notice of privacy practices: you have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of out treatment, payment activities, and healthcare operations, of uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our practices as described in out Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information we maintain. You may obtain a copy of our Notice of Privacy Practices, Including any revisions of our notice at any time by contacting: Telephone: 516-934-0222 Fax: 516-934-0221

I, _____, have the right to read and consider the contents of this form and your Notice of Privacy Practices. I understand by signing this consent form, I am giving my consent to your used and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

SIGNATURE: _____, **Date:** _____/_____/_____

If this consent has to be signed by a personal representative on behalf of a patient; please complete the following:

***Personal representative's name**:* _____ ***Relationship to the patient**:* _____

(IF SIGNED ABOVE DO NOT SIGN BOTTOM PORTION)

YOU ARE ENTITILED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

Right to revoke: You will have the right to revoke this consent at any time by giving written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

REVOCATION CONSENT: I revoke my consent for your used and disclosure of my health information for treatment, payment activities and health care operations,

I understand that revocation of my consent will affect any action you took in reliance on my consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.

I, _____, revoke my consent to the Notice of Privacy Practices

SIGNATURE: _____, **Date:** _____/_____/_____