PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you.

Patient Name _____D.O.B._____

Address: _____City:_____State:_____Zip:_____

Home phone: _____Cell:_____Work:_____

Email address: _____SS#:_____

Emergency Contact (Name/Phone #) _____

How did you hear about us? _____

Pharmacy_____

Medical History

1)Are you under the care of a physician? .....Yes ☐ No ☐

If yes, for what reason(s)? _____

2) Are you presently taking any medications/drugs/pills/herbals/supplements?

.....Yes No

If yes, please list: _____

3) (Women) Is there a chance you are pregnant? .....Yes ☐ No ☐

If yes, First, second, third trimester? _____

4) Are you allergic/sensitive to: ☐None ☐Codeine ☐Penicillin ☐Local Anesthetic ☐Latex

Other: _____

5) Do you smoke, chew tobacco, or use E-cigarettes? .....Yes ☐ No ☐

6) Do you have diabetes?.....Yes ☐ No ☐

If yes, please indicate: ☐ Type 1 ☐ Type 2

7) Do you have or have you ever had:

Abnormal Blood Pressure	Yes	No
Alzheimer's Disease	Yes	No
Anemia	Yes	No
Arthritis/Gout	Yes	No
Artificial heart Valve/Stent	Yes	No
Artificial Joint Replacements	Yes	No
Asthma	Yes	No
Blood Disease	Yes	No
Breathing Problems	Yes	No
Bruise Easily	Yes	No
Cancer	Yes	No
Chemoterapy/Radiation	Yes	No
Chest Pains	Yes	No
Cold Sore/Fever Blisters	Yes	No
Congenital Heart Disorder	Yes	No
Convulsions	Yes	No
Diabetes	Yes	No
Epilepsy /Seizure	Yes	No
Excessive Bleeding	Yes	No
Fainting Spells/Dizziness	Yes	No
Frequent Cough	Yes	No
Frequent Headaches	Yes	No
Glaucoma	Yes	No
Hay Fever	Yes	No
Heart Attack/Failure	Yes	No
Heart Murmur	Yes	No
Heart Pacemaker	Yes	No
Heart Surgery	Yes	No

Hepatitis	Yes	No
Herpes	Yes	No
High Blood Pressure	Yes	No
HIV/AIDS	Yes	No
Kidney Disease/ Dialysis	Yes	No
Leukemia	Yes	No
Liver Disease	Yes	No
Low Blood Pressure	Yes	No
Lung Disease	Yes	No
Oral Herpetic Lesion	Yes	No
Osteoporosis	Yes	No
Pain in The Joints	Yes	No
Psychiatric Care	Yes	No
Recent weight loss	Yes	No
Rheumatic Fever	Yes	No
Sexually Transmitted Disease	Yes	No
Sinus Trouble	Yes	No
Stroke	Yes	No
Thyroid Problem	Yes	No
Tumor	Yes	No
Tuberculosis	Yes	No
Ulcers	Yes	No

Dental History

1) Former Dentist _____

What was done at your last visit? _____ How often do you visit the dentist?_____

What do you hope to get out of this visit? _____

_____

2) Has any dental treatment been recommended to you that you have not completed? ____

_____

What has kept you from returning to the dentist? _____

3) Are you aware of any dental problems .....☐Yes ☐ No

If yes, please explain: _____

_____

Are you in any pain? _____

4) Please rate the present condition of your mouth: Poor 1 2 3 4 5 6 7 8 9 10 Excellent

5) Are your teeth sensitive to: ☐ Nothing ☐ Sweet ☐ Cold ☐ Heat ☐ Pressure

6) Would you like a whiter smile? .....☐ Yes ☐ No

7) Would you like straighter teeth? .....☐Yes ☐ No

8) Have you had your teeth straightened/worn braces? .....☐Yes ☐ No

9) Are you concerned with bad breath (malodor)? .....☐Yes ☐ No

10) Are you concerned with grinding or clenching your teeth(bruxism)? ...☐Yes ☐ No

11) Do you wear a bite guard? .....☐Yes ☐ No

12) Any TMJ problems? (Does your jaw joint make noise or lock up?) .....☐Yes ☐ No

13) Is there anything else that would be valuable for your dentist to know to best care for you? _____

_____

_____

☐ I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

☐ I authorize the release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist.

☐ I have accurately advised my dental care provider of my current health status and any dietary or herbal supplements, medications, and/or drugs (including recreational and over the counter) that I am taking or have taken in the last week.

Patient Signature _____Date:_____

_____(Parent/Guardian)

Patient Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health.

The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

Please Note: Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express and CareCredit. Outside financing is available upon request and approval.

Please note: Additional fees will be applied for returned checks. All account balances over 90 days are subject to a $50.00 late fee.

Minors accompanied by the parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service. Unaccompanied Minors: The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or nonemergency treatment may be denied.

Missed Appointments) and Cancellations: Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we require at least **a 24hour** notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A charge of **$100.00** may be assessed for multiple missed, short notice or cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice.

Communications with you: By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us. We or our agents may call by telephone regarding your account. You agree that we may place such calls using an automatic dialing/announcing device. You agree that we may make such calls to a mobile telephone or other similar device. You agree that we may, for training purposes or to evaluate the quality of our service, listen to and record phone conversations you have with us.

Do you have insurance?

As a courtesy to you, we will help you process all of your dental insurance claims. Please Understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of

your benefits. Your insurance company and your plan benefit ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.

- All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. I authorize the release of any information concerning my (or my child's) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- We ask that you pay the deductible, co-payment and co-insurance, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, Discover, American Express and CareCredit at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that whether or not I have insurance, responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Patient/Parent name printed_____

Patient/Parent signature_____Date_____

PAYMENT ARRANGEMENT FORM

NAME OF PATIENT: _____

I agree that I am responsible for all services rendered to the Patient and that payment is due and payable to the Practice at the time services are rendered and that health, dental and accident insurance policies are an arrangement between my insurance carrier and me. I agree to pay all deductibles and copays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage). I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid by my insurance company. I also understand that if the Practice cannot verify insurance benefits eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered. I understand that the Practice may charge: 1) a late fee if payment on my account is not received by the due date; 2) an amount equal to $35.00, but not to exceed the maximum amount permitted by law for each returned check, and 3) a fee for each appointment that is missed/canceled without at least 24 hours advance notice. I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the Practice

Primary Insurance:

Primary Insurance Name: _____Address_____

_____

Phone Number_____

Name of Insured_____Relashionship_____

ID Number_____Group Number_____

Secondary Insurance:

Secondary Insurance Name: _____Address_____

_____

Phone Number_____

Name of Insured_____Relashionship_____

ID Number_____Group Number_____

I acknowledge having received a copy of the Practice's Notice of Privacy Practices. I agree that a photocopy of this authorization is as valid as the original.

Signature of Responsible Party: _____Date:_____

ACKNOWLEDGE OF RECEIPT

OF NOTICE OF PRACTICES AND CONSENT FORM

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in our Notice of Privacy Practices, updated effective September 23, 2013.

We are permitted to review our Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

Authorization of PHI Disclosure

The information described above may be disclosed to the following recipients:

• Name of Person #1: _____Relationship to You: _____

• Name of Person #2: _____Relationship to You: _____

I understand that 72 Park Dental will not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization form, except in the following situations:

- If the medical information to be disclosed will result from treatment for research purposes72 Park Dental will not provide the treatment if I am unwilling to sign this authorization form.
- If the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, 72 Park Dental will not provide the treatment if I am unwilling to sign this authorization form.

Revocation of PHI Disclosure

I understand that I may revoke this authorization by completing a new Acknowledgement of Receipt of Notice of Privacy Practices and Consent Form. I understand that I may not revoke this authorization during an insurance contestability period or with respect to disclosures that Smiles on the Hudson may have already made in reliance on this authorization. If I revoke this authorization, Smiles on the Hudson will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. I understand that when Smiles on the Hudson discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information. By signing below, I am acknowledging that I have received a copy of Smiles on the Hudson's Notice of Privacy Practices. I am also giving MDSC consent to disclose my protected health information to the person(s) listed above until such time a new Acknowledgement of Receipt of Notice of Privacy Practices and Consent Form is completed by me. I also understand and agree to the terms of this authorization.

Patient/Parent name printed_____

Patient/Parent signature_____Date_____