

Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1

ABOUT YOU

Today's Date: _____

E-mail Address: _____

Name: _____
last First MI Mr Mrs Ms Dr

I prefer to be called: _____ Male Female

Birthdate: ____/____/____ Age: ____ SS#: _____

Home Address: _____
Apt/Condo #

City State Zip

Single Married Partnered Divorced/Separated Widowed

Hm #: (____) _____ Cell #: _____

Wk #: (____) _____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

City State Zip

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Person Responsible for Account: _____

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SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: (____) _____ Ext: ____ SS #: _____

Birthdate: ____/____/____ DL #: _____

Relative or Friend not living with you.

His / Her Name: _____ Relation: _____

Wk #: (____) _____ Hm #: (____) _____

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INSURANCE

Primary Insurance

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

City State Zip

Secondary Insurance

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

City State Zip

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature _____

Date _____

CONTINUED ON BACK

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MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Have you had any metal rods, pins or implants? Yes No

Are you taking any prescription / over-the-counter drugs? Yes No

Please list each one: _____

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) Yes No

If so, when? _____

Have you ever taken Fosamax, or any other bisphosphonate? Yes No

For Women: Are you using a prescribed method of birth control? Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding / Hemophilia | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes / Fever Blisters |
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol / Drug Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N HIV |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized for Any Reason |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion | <input type="checkbox"/> Y <input type="checkbox"/> N Lupus |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N Colitis | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack / Surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease |

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N Jewelry/Metals | <input type="checkbox"/> Y <input type="checkbox"/> N Sulfur |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Latex | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |

Please list any other drugs/materials that you are allergic to: _____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? Y N
If Yes, please explain. _____

Has there been any change in your health status since your last visit? Y N
If Yes, please explain. _____

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DENTAL HISTORY

Why have you come to the dentist today? _____

Are you currently in pain? Yes No

Do you require antibiotics before dental treatment? Yes No

Your current dental health is: Good Fair Poor

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Do you floss daily? Yes No Brush daily? Yes No

Type of bristles on your toothbrush? Hard Medium Soft

Have you ever had gum treatment? Yes No

Do your gums ever bleed? Yes No Ever itch? Yes No

Have you ever had periodontal disease? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have any loose teeth? Yes No

Do you still have wisdom teeth? Yes No

Would you like fresher breath? Yes No Whiter teeth? Yes No

Are you happy with the way your smile looks? Yes No

If not, what would you change? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature _____

Date _____

OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____

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MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? Y N
If Yes, please explain. _____

Has there been any change in your health status since your last visit? Y N
If Yes, please explain. _____

Patient Signature _____ Date _____

Dentist Signature _____ Date _____

Patient Signature _____ Date _____

Dentist Signature _____ Date _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

*Section A: **Patient Giving Consent***

Name: _____

Address: _____

Telephone: _____ SS#: _____

*Section B: **TO THE PATIENT: PLEASE READ THE FOLLOWING STATEMENT***

Purpose for Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care options.

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 our treatment, payment activities and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. You may obtain a copy of our Notice of Privacy Practices including any revisions of our Notice, at any time.

We reserve the right to change our privacy practices as described in our 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.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation. 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.

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

Signature _____ Date _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Representative's Name: _____

Relationship to Patient: _____

University Dental PC
43-07 214th Place
Bayside, New York 11361
718-225-0515

Silverman & Gott, L.L.P
2592 Merrick Road
Bellmore, NY 11710
516-781-9700

Office Policy

It is our goal to provide you with the highest level of dental care possible. We are committed to both improving your current health, and preventing future dental problems.

We must make our treatment recommendations based on the best available option to you.

Unfortunately, most dental insurance companies provide coverage only for what they deem to be the minimally accepted standard of care. We therefore will in no way allow insurance benefits to dictate treatment.

Due to clinical situations, a proposed treatment plan may change. We will inform you of any changes in treatment as they occur, and of any changes in your financial responsibility.

All Dental work requires a non-refundable down payment of 50% and the balance must be paid two weeks before completion of the treatment.

For our insured patients, your co-payment and deductible are due at the time of service. **The amount of co-payment quoted is based on the best information we have available at the time of the estimate.** When we receive payment from your insurance company, we will make any necessary adjustments, and you will be charged for any remaining balance.

For non-insured patients, your full payment is due at the time of your visit, unless other arrangements have been made in advance. If payment arrangements are not kept as agreed, the original arrangement will be forfeited and payment in full will be expected at time of service. No exceptions.

For any and all senior citizen discounts, payment must be made in full at time of service unless otherwise specified.

All appointments are exclusively reserved. Therefore, a 24 hour advance notice is required if you need to cancel or change this appointment. We reserve the right to charge a fee without sufficient notice.

Our office charges \$40 for returned checks.

Any outstanding balance over 60 days will incur finance charges. If the balance remains unpaid, your account may be forwarded to collection and any fees incurred will be added to your account.

To insure timely receipt of all payments, we request that all patients leave a credit card on file with their consent. We reserve the right to apply to that card any balances due on you and/or your family account.

.....
Please apply any balance to the following credit card:

Visa _____ Mastercard _____ American Express _____ Discover _____

Credit Card Number _____

Expiration Date _____ Security Code _____

Billing Address of Credit Card _____

I have read all the information listed above and agree to comply with all office policies.

Print Name

Signature

Date

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Bayside, New York 11361
718-225-0515

Silverman & Gott, LLP
2592 Merrick Road, Suite C
Bellmore, New York 11710
516-781-9700

Authorization for Use of Signature On File for Claim Authorization

Subscriber Social Security Number

Subscriber Name

I, _____, authorize _____
Patient/Subscriber Name Provider Name

to mark the section "Subscriber's" or "Authorized Person's" signature with the notation:
"Signature on File."

This section authorizes:

- 1) The release of any medical information necessary to process all claims.
- 2) Payment of dental/medical benefits to the above provider of service.

This authorization will remain in effect until terminated in writing by the enrollee.

Subscriber/Patient Signature

Date

NO-SHOW / LATE CANCELLATION POLICY

Silverman & Gott Family Dentistry is committed to meeting all of our patients' health care needs.

Please be advised of the following policy:

All appointments must be cancelled by 3pm of the previous day (or by 2pm on the Saturday before a Monday appointment) to avoid incurring a no-show or late cancellation fee being charged to you.

PLEASE NOTE: Insurances do not cover no-show or late cancellation fees so the patient will be responsible for payment.



NO-SHOW / LATE CANCELLATION fee of \$50 will be charged to you if an appointment either is missed, or not cancelled by 3pm on Monday-Friday or 2pm on Saturday of the previous business day.

Patient (or Responsible Party) Signature

Date