Patient Information

Date: _____

Patient Name:_____ Birth Date: _____ Social Security #:_____
Last, First MI (Preferred Name)

E-mail: _____ May we contact you via email or text message? ☐ Yes ☐ No

Phone (H): _____ (W): _____ (C):_____

Address:_____ Apt#: _____ City:_____ State: ____ Zip Code: _____

Gender: ☐ Female ☐ Male Check appropriate box: ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Single

Employer:_____If patient is a student name of School/College: _____

Responsible Party

☐ Patient is responsible for the account

Name of Person Responsible for this Account: _____Relationship to Patient: _____

Social Security #: _____ Birth Date: _____

Address: _____ Apt#: _____ City:_____ State: ____ Zip Code: _____

Gender: ☐ Female ☐ Male Check appropriate box: ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Single

Phone (H): _____ (W): _____

Is the Responsible Party Currently a Patient in our Office? ☐ Yes ☐ No

Patient Dental History

	YES	NO
1. Do you feel pain to any of your teeth?	☐	☐
2. Do your gums bleed while brushing or flossing?	☐	☐
3. Are your teeth sensitive to hot or cold sweet or sour liquids/foods?	☐	☐
4. Have you ever had braces?	☐	☐
5. Have you ever had a difficult extraction or prolonged bleeding following extractions?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐

Patient Medical History

Date of Last Medical Exam: _____ Name/Phone Number of Doctor: _____

Are you allergic to or have you had an allergic reaction to the following: ☐ No known allergies

☐ Codine ☐ Latex ☐ Iodine
☐ Penicillin ☐ Aspirin ☐ Local Anesthetic
☐ Barbiturates ☐ Sedatives (eg. Novicaine)
☐ Other: _____

Women Only

Are you pregnant or think you may be pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No
Are you taking birth control? ☐ Yes ☐ No

1. Are you taking Bisphosphonate? ☐ Yes ☐ No
2. Are you taking any medication(s)? ☐ Yes ☐ No

If yes, what medication(s) are you taking?

_____
_____
_____

3. Are you under medical treatment now? ☐ Yes ☐ No
4. Have you ever been hospitalized for any surgical operation or serious illness? ☐ Yes ☐ No
5. Do you use tobacco? ☐ Yes ☐ No
6. Do you use alcohol, cocaine or other drugs? ☐ Yes ☐ No

Have you ever had any of the following. Please check those that apply. ☐ No Medical Condition

☐ AIDS or HIV infection
☐ Anemia
☐ Angina
☐ Arthritis
☐ Asthma
☐ Cancer
☐ Cardiac Pacemaker
☐ Chest Pains
☐ Diabetes
☐ Easily Winded
☐ Emphysema
☐ Epilepsy/Convulsions
☐ Fainting/Seizures
☐ Frequently Tired
☐ Glaucoma
☐ Hay Fever/ Allergies
☐ Heart Attack
☐ Heart Disease
☐ Heart Murmur
☐ Heart Trouble
☐ Hepatitis/ Jaundice
☐ High Blood Pressure
☐ Joint Replacement or Implant
☐ Kidney Diseases
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Radiation Therapy
☐ Recent Weight Loss
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sexually Transmitted Disease
☐ Stomach Troubles/ Ulcers
☐ Stroke
☐ Swollen Ankles
☐ Thyroid Problems
☐ Tuberculosis
☐ Other: _____
_____
_____
_____

Sleep History

	YES	NO
1. Do you snore or have been told you snore?	☐	☐
2. Have you been told you stop breathing or gasp during sleep?	☐	☐
3. Are you often fatigued during the day?	☐	☐
4. Do you fall asleep sitting, reading, watching TV, or driving?	☐	☐
5. Have you ever been told that you s grind your teeth during sleep?	☐	☐
6. Have you ever had a sleep study?	☐	☐
7. Do you have Obstructive Sleep Apnea or suspect you have OSA?	☐	☐
8. Are you currently being treated for OSA or another sleep disorder?	☐	☐

Insurance Information

Primary Dental Insurance ☐ Yes ☐ No

Insurance Plan Name:
_____

Name of Insured:
_____

DOB: _____ SS#/ID#: _____

Is insured a patient? ☐ Yes ☐ No

Relationship to Patient: _____

Secondary Dental Insurance ☐ Yes ☐ No

Insurance Plan Name:
_____

Name of Insured:
_____

DOB: _____ SS#/ID#: _____

Is insured a patient? ☐ Yes ☐ No

Relationship to Patient: _____

Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Consent

Consent for Services

I authorize the dental health professionals (Doctors and Staff) of Jackson Heights Family Dental/ All Dental Specialist to perform those procedures as deemed necessary or advisable to maintain my dental health, including arrangement and/or administration of any sedative, analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic, or surgical treatments. I understand that the administration of local anesthetic may cause an unpleasant reaction or side effects which may include, but are not limited to bruising, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness.

Financial Policy

Payment for all services rendered is due the day of service unless prior arrangements have been made.
The following financial arrangements are accepted for all services over $500:
-A book keeping courtesy of 6% will be extended when payment is made in full by cash or check before treatment begins.
- We offer 3, 6, or 12 month deferred interest payments with credit approval through an outside finance company. (Credit approval required).
-We offer extended financing up to 48 months with a fixed interest rate through an outside finance company. (Credit approval is required).
-Payments can be made during the course of treatment. 1/3 of the total case fee is due to secure the appointment, 1/3 during treatment and 1/3 before completion.

Publication of Records

I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for either the advancement of dentistry or in promotional materials. My identity will not be revealed to the general public.

Dental Insurance

Our estimates regarding your dental insurance a given as carefully as possible. These estimated are based on information currently available and past history of any specific insurance company. However, your insurance carrier will ultimately decide on the benefit to be released. Our financial arrangement with you will include your estimated dental insurance but you are responsible for ALL treatment fees.

Acknowledgement

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Privacy Notice

We are required to provide you with a copy of our practices written policy on privacy. The notice provides in detail the use and disclosures of your protected health information that may be made by this practice, your individual rights, how you may exercise these rights, and the practice's legal duties with respect to your information. I was given the opportunity to read the Notice of Privacy Practices. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

To Our Valued Patient Letter

I have received the "To our Valued Patient Letter". The letter contains information about the office policy.

_____ Date: _____ Relations hip to Patient: _____
Signature of patient, parent, or guardian

Language

What Language do you speak? __English __Spanish __Chinese (Cantonese) __Chinese (Mandarin) __Other _____

Do you need an interpreter? __Yes __No Who completed this form: _____ Relationship to patient: _____

Referral Information

☐ Friend/Relative *Name of person: _____ ☐ Insurance ☐ Internet
☐ Doctor *Name/Phone Number: _____ ☐ Walking by ☐ Other: _____
☐ Post Cards/other __ Received via Mail __ Office Representative