Perfect Dental Care PC

Last Name	First Name	Middle Initial						
Date of Birth	Social Security Number	Gender: Male Female						
Home Address	Apt # City	State Zip Code						
Home Phone	Other Phone I Cell Work	Marital Status						
Email Address								
Dental Insurance Name and Policy #								
	t □Not Employed □tudent □t							
Pharmacy (name and phone number):							
EMERGENCY INFORMATION								
Last Name	First Name	Relationship to Patient						
Home Phone	Work Phone	Other Phone						
INSURANCE POLICY HOLDER INFORMATION								
Relationship to Patient Self Last Name	Spouse Parent Other First Name							
Date of Birth	Social Security Number	Gender: Male Female						
Home Address	Apt # City	State Zip Code						
Home Phone	Other Phone ICell Work							
Employment Status: Full Part Not Employed Student Other Please complete all information – Thank you!								

PATIENT NAME: _____

DERVIAL HISTORY Deter of last dental visit									
General dentist Date of last dential x-rays Prease check if you ever have/hat	Dessen for to dess's sisit				D	- 4 f 1-	at dental cisit		
Pleace check if you ever have had: Bit hereanth Yes No Had. nock, jaw pain or arches Yes No Different on it notage Chew on one side of mouth Different of holdent fillings Chew on one side of mouth Dow to hold on threathing Different of holdent it reamment Stankless to have Different of holdent it reamment Different of holdent it reamment Stankless to have Different of holdent it reamment Different of holdent it reamment Stankless to have Different of holdent it reamment Different of holdent it reamment Stankless to have Different of holdent it reamment Different of holdent it reamment Yes No The or one even had holdent or standard use mouth Stank store on the holding Different of holdent it reamment Different of holdent it reamment Norms wollen on theoding Different of holdent it reamment Different of holdent it reamment Norms wollen on theoding Different of holdent it reamment Different of holdent it reamment Norms wollen on theoding Different of holdent it reamment Different of holdent it reamment Have you ever had a blood transflusion? Yes No Taking birth control pills? <td< td=""><td colspan="6"></td><td></td><td></td></td<>									
Bad breath Bibses on lips or moath Cew on one side of moath Bibses on lips or moath Bibses on lips or mosth Bibses on lips or moath Bibses on lips or mosth Bibses on lips or moath Bibses on lips or	Uchicial uchitist Date of last uchital x-rays								
Bad breach	Please check if you ever have/had:								
Buning secantion in tongue			Head, neck,				Have you ever had an allergic reaction t	o Novocaine.	
Clastetic pape or cigar smoking Orthozonic freatment	Buming sensation in tongue Chew on one side of mouth		Loose teeth Mouth brea	Loose teeth or broken fillings Mouth breathing			local or general anesthetics? Yes N If Yes, please explain		
Food collection between teech	Smokeless tobacco		Periodontal	Orthodontic treatment Image: Constraint of the second					
Game studie or bleeding How often do you busk?	Food collection between teeth Teeth grows or sore spots in		(cold, heat,				Yes No If Yes, please explain		
MEDICAL HISTORY Physician's name Date of last visit Physician's address Have you ever had alood transfusion? Yes No If Yes, please describe Have you ever had alood transfusion? Yes No If Yes, give approximate dates Women only: Are you pregnant? Yes No Nursing? Yes No Please check if you ever have/had:									
Physician's name	Gums swollen or bleeding		How often of	io you brush?					
Physician's name	MEDICAL HISTORY								
Have you ever had any serious illnesses or operations? Yes No If Yes, please describe									
Have you ever had a blood transfusion? Yes No If Yes, give approximate dates Women only: Are you pregnant? Yes No Nursing? Yes No Please check if you ever have/had:	Have you ever had any serious	illnesses or	operations?	Yes No If Yes, pl	ease de	escribe_			
Please check if you ever have/had: Yes No Yes No Allergies, hay fever, sinusitis Headaches Stow healing wounds Image: Stroke	Have you ever had a blood tran	sfusion?	Yes No I	f Yes, give approximation	te dates	s			
Yes No Yes No Allergies, hay fever, sinusitis	Women only: Are you pregn	ant? Yes	No	Nursing? Yes No		Taking	g birth control pills? Yes No		
Allergies, hay fever, sinusitis Headaches Heart murmur Heart murmur Heart problems Stroke Stroke Arthritis, Rheumatism Heart problems Stroke Stroke	Please check if you ever have/had:	X N		V	NT				
Anemia	Allergies hay fever sinusitis					Slow he	aling wounds		
Arthritis, Rheumatism Heart problems Swelling of feet or ankles Image: Stress of the stress of						-			
Artificial heart valves	Arthritis, Rheumatism		Heart proble			Swelling of feet or ankles			
Artificial joints Herpes Tonsilitis Asthma High blood pressure Tuberculosis Bequired hospitalization HIV Tumor or growth on head/neck Date of last episode Any immune deficiency Ulcer Date of last episode Any immune deficiency Ulcer Date of last episode Low blood pressure Do you wear contact lenses? Blood disease, clotting disorders Nitral valve prolapsed Do you consume alcoholic beverages? Cancer Netoprosis Aligation treatment Chemical dependency Pacemaker Altery ou allergic to Penicillin, Aspirin or other Cortisone treatment Radiation treatment Diabetes Shortness of breath Glaucoma <t< td=""><td>Artificial heart valves</td><td></td><td>Hepatitis ty</td><td>pe</td><td></td><td colspan="2">Thyroid problems</td><td></td></t<>	Artificial heart valves		Hepatitis ty	pe		Thyroid problems			
Required hospitalization HIV Tumor or growth on head/neck Have you used steroids Any immune deficiency Ulcer Date of last episode Any immune deficiency Ulcer Bleeding abnormally with Kidney disease Venereal disease operations or surgery Nitral valve prolapsed Do you consume alcoholic beverages? Blood disease, clotting disorders Osteoprosis Are you allergic/sensitive to Latex? Chemical dependency Pacemaker Are you allergic/sensitive to Latex? Chemotherapy Radiation treatment Harei core Harei core Cough, persistent or bloody Rheumatic fever List any medication that you are taking: Epilepsy Sinus trouble List any medication that you are taking: Epilepsy Skin rash Date	Artificial joints			Herpes		Tonsillitis			
Have you used steroids				High blood pressure					
Date of last episode									
Bleeding abnormally with				e deficiency					
operations or surgery Iow blood pressure Iow bl									
Blood disease, clotting disorders Image: Mitral valve prolapsed Image: Do you consume alcoholic beverages? Image: Do you consum alcoholic beverages? Image: D									
Cancer Osteoporosis Ar you allergic/sensitive to Latex? Image: Cancer Chemical dependency Osteopenia Allergic to Penicillin, Aspirin or other Image: Cancer Chemotherapy Pacemaker Allergic to Penicillin, Aspirin or other Image: Cancer Cortuatory problems Pacemaker Image: Cancer Image: Cancer Image: Cancer Cortuatory problems Pacemaker Pacemaker Image: Cancer Image: Cancer Image: Cancer Cough, persistent or bloody Pacematic fever Pacematic fever Pacematic fever Image: Cancer Image:									
Chemical dependency Osteopenia Image: Chemotherapy	-								
Chemotherapy Image: Chemotherapy Image: Chemotherapy Circulatory problems Radiation treatment Image: Chemotherapy Cortisone treatment Image: Chemotherapy Image: Chemotherapy Cortisone treatment Image: Chemotherapy Image: Chemotherapy Cough, persistent or bloody Image: Chemotherapy Image: Chemotherapy Diabetes Image: Chemotherapy Image: Chemotherapy Emphysemia Image: Chemotherapy Image: Chemotherapy Epilepsy Image: Chemotherapy Image: Chemotherapy Fainting Image: Chemotherapy Image: Chemotherapy Glaucoma Image: Chemotherapy Image: Chemotherapy Image: Chemotherapy Image: Chemotherapy Image: Chemotherapy Image: Chemotherapy Image: Chemotherapy Image: Chemotherapy Glaucoma Image: Chemotherapy Image: Chemotherapy Image: Chemotherapy Image: Chemotherapy Image: Chemotherapy Image: Chemotherapy Image: Chemotherapy Sinst trouble Image: Chemotherapy Image: Chemotherapy Image: Chemotherapy Image: Chemotherapy Image: Chemotherapy Image: Chemotherapy Image: Chemot			-					느님님	
Cortisone treatment Respiratory disease If Yes, please specify				naker drugs?					
Cough, persistent or bloody Rheumatic fever Scarlet fever Shortness of breath Shortness of breath Sinus trouble Sickle cell anemia Skin rash List any medication that you are taking: List any medication that you are taking: List any medication that you are taking: Sickle cell anemia Skin rash Date Date Date Date Date Date Date Date Date Date Date 	Circulatory problems								
Diabetes			1 2						
Emphysemia Epilepsy Fainting Glaucoma Skin rash List any medication that you are taking: Shortness of breach List any medication that you are taking: List any medic									
Epilepsy Sinus trouble Image: Construction of the set of my knowledge. Fainting Skin rash Image: Construction of the set of my knowledge. AUTHORIZATION AND RELEASE Date									
Fainting Sinds trouble Sickle cell anemia						List any medication that you are taking:			
Glaucoma Image: Stelle cell alemna Image: Stelle cell alem				_					
AUTHORIZATION AND RELEASE I have read and answered the above questions to the best of my knowledge. Patient/Guardian signature Date	-								
I have read and answered the above questions to the best of my knowledge. Date Date Date	Glaucoma		Skin rash						
Patient/Guardian signature Date	AUTHORIZATION AND RELEASE								
	I have read and answered the above questions to the best of my knowledge.						Date		
Reviewed by:	Patient/Guardian signature					Date			

PATIENT CONSENT FORM (HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)

2. Obtaining payment from third party payers (e.g. my insurance company)

3. The day to day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this	day of	, 2017
Print Patient Nam	e:	
Relationship to Pa	tient:	
Signature:		

FINANCIAL POLICY

Payment is due at the time of your appointment. For your convenience we offer the following methods of payments: MasterCard, Visa, Discovery and American Express:

Credit card #_____

Exp Date _____

We will file for covered services for all insurance plans in which we participate. If you are covered by insurance, you will need to be prepared to pay your deductible and any co-payments at the time of your appointment. You will also need to have your complete insurance information with you.

Please contact your insurance carrier for your benefit information and whether or not services will be covered in our office. Please call your insurance company if you have any questions about your benefits. It is also important to note that some procedures will be covered under your medical insurance, while others are covered under dental insurance.

Any balance on your account not paid by your insurance carrier within 30 days will become your responsibility and payment will be due from you. We do all we can to provide pertinent medical/dental information on your claim. Please contact the customer service representative of your insurance plan if you are dissatisfied with your claim denial and feel your service should be covered.

If your account is unpaid within 45 days from the date of service, it will be sent to a collections agency with a 50% collections fee added.

Cash Patients

If you are unable to pay your bill in full at the time service is rendered we will be happy to arrange financing for you or create a customized payment plan allowing you to pay your full bill within one year. Please do not hesitate to ask us to set this up for you. If you are to have surgery under **general anesthesia (asleep)**, we do require that you pay a down payment of **\$500** by the date of your surgery. If you have any questions about our financial policy, please call us at 212 644-7009. Our staff is always willing to assist you.

Cancellation Policy

Appointments that are missed or cancelled with less than 24 hours notice not only prevent you from receiving care but also prevent others from being able to receive care at that time. For this reason such **cancellations** or missed appointments will result in a **fee of \$100**. If your appointment was for a procedure under general anesthesia, the fee will be \$300. This fee may be waived if the reason for cancellation is beyond the control of the patient.

Collections and Legal Fees

If it becomes necessary for an account to be turned over to an attorney or collections agency the costs of such action will be the responsibility of the patient

Patient/Parent or Legal Guardian