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 Cell Work Marital Status

_____

Email Address

_____

Dental Insurance Name and Policy #

_____

Employment Status: ☐ Full ☐ Part ☐ Not Employed ☐ Student ☐ Other Employer

Referred By: _____

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 Spouse Parent Other _____

Last Name First Name

_____

Date of Birth Social Security Number Gender: Male Female

_____

Home Address Apt # City State Zip Code

_____

Home Phone Other Phone Cell Work

_____

Employment Status: ☐ Full ☐ Part ☐ Not Employed ☐ Student ☐ Other

Please complete all information – Thank you!

PATIENT NAME: _____

DENTAL HISTORY

Reason for today's visit_____ Date of last dental visit_____
General dentist_____ Date of last dental x-rays_____

Please check if you ever have/had:

	Yes	No
Bad breath	☐	☐
Blisters on lips or mouth	☐	☐
Buming sensation in tongue	☐	☐
Chew on one side of mouth	☐	☐
Cigarette, pipe or cigar smoking	☐	☐
Smokeless tobacco	☐	☐
Dry mouth	☐	☐
Food collection between teeth	☐	☐
Teeth grows or sore spots in your mouth	☐	☐
Gums swollen or bleeding	☐	☐

	Yes	No
Head, neck, jaw pain or arches	☐	☐
Lip or cheek biting	☐	☐
Loose teeth or broken fillings	☐	☐
Mouth breathing	☐	☐
Orthodontic treatment	☐	☐
Periodontal treatment	☐	☐
Sensitivity to pressure or irritants (cold, heat, sweet)	☐	☐

How often do you floss?_____
How often do you brush?_____

Have you ever had an allergic reaction to Novocaine, local or general anesthetics? Yes No
If Yes, please explain_____
_____
_____

Have you ever had trouble from previous dental care? Yes No
If Yes, please explain_____
_____
_____

MEDICAL HISTORY

Physician's name_____Date of last visit_____Physician's address_____
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 Taking birth control pills? Yes No

Please check if you ever have/had:

	Yes	No
Allergies, hay fever, sinusitis	☐	☐
Anemia	☐	☐
Arthritis, Rheumatism	☐	☐
Artificial heart valves	☐	☐
Artificial joints	☐	☐
Asthma	☐	☐
Required hospitalization	☐	☐
Have you used steroids	☐	☐
Date of last episode_____		
Bleeding abnormally with operations or surgery	☐	☐
Blood disease, clotting disorders	☐	☐
Cancer	☐	☐
Chemical dependency	☐	☐
Chemotherapy	☐	☐
Circulatory problems	☐	☐
Cortisone treatment	☐	☐
Cough, persistent or bloody	☐	☐
Diabetes	☐	☐
Emphysemia	☐	☐
Epilepsy	☐	☐
Fainting	☐	☐
Glaucoma	☐	☐

	Yes	No
Headaches	☐	☐
Heart murmur	☐	☐
Heart problems	☐	☐
Hepatitis type_____	☐	☐
Herpes	☐	☐
High blood pressure	☐	☐
HIV	☐	☐
Any immune deficiency	☐	☐
Jaundice	☐	☐
Kidney disease	☐	☐
Low blood pressure	☐	☐
Mitral valve prolapsed	☐	☐
Osteoporosis	☐	☐
Osteopenia	☐	☐
Pacemaker	☐	☐
Radiation treatment	☐	☐
Respiratory disease	☐	☐
Rheumatic fever	☐	☐
Scarlet fever	☐	☐
Shortness of breath	☐	☐
Sinus trouble	☐	☐
Sickle cell anemia	☐	☐
Skin rash	☐	☐

	Yes	No
Slow healing wounds	☐	☐
Stroke	☐	☐
Swelling of feet or ankles	☐	☐
Thyroid problems	☐	☐
Tonsillitis	☐	☐
Tuberculosis	☐	☐
Tumor or growth on head/neck	☐	☐
Ulcer	☐	☐
Venereal disease	☐	☐
Weight loss, unexplained	☐	☐
Do you wear contact lenses?	☐	☐
Do you consume alcoholic beverages?	☐	☐
Are you allergic/sensitive to Latex?	☐	☐
Allergic to Penicillin, Aspirin or other drugs?	☐	☐

If Yes, please specify_____
_____
_____

List any medication that you are taking:_____
_____
_____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Date _____

Patient/Guardian signature_____

Date_____

Reviewed by:_____

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 Name: _____

Relationship to Patient: _____

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 Date