

Specialized Dentistry of New York
 150 East 58th Street, Suite 3200
 New York, NY 10155
 (212)752-7937

Chart #: _____
 FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last First MI
 Dr./Mr./Miss/Ms./Mrs _____ Social Security #: _____ Birth Date: _____
 Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____
 Best Time to Call: _____ E-mail: _____
 Address: _____
Street Apartment #

City State Zip Code

Health Information

Chief Complaint: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Temporomandibular Joint Disorder (TMJ) or Jaw joint and/or facial pain |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Bite/ Occlusion Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joints / Replacement | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur (Mitral Valve Prolapse) | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Allergies to food/other products |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> Emphysema/Lung problems | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Thyroid Problems | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis | |
| | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tumors/Malignancies | |

• Do you have any allergies to medications? Yes No If yes, please list _____

• Do you require pre-medication prior to treatment? Yes No

• Are you currently taking any medication(s)? Yes No

If yes, please list: _____

• Are you taking or have ever taken Bisphosphonate medication (for osteoporosis)? Yes No

If so, which one and for how long? _____

• Are you taking Aspirin? Yes No

• Are you taking Vitamin E? Yes No

• Are you taking Birth Control Pills? Yes No

• Have you ever experienced problems with dental anesthetics (novacaine)? Yes No

• Have you been hospitalized within the last 5 years? Yes No

If yes, please explain: _____

• Name of Family Physician: _____ Phone: _____

• Are you pregnant? Yes No

• Do you smoke? Yes No If yes, how many packs per day? _____

• How long since your last Dental Examination? _____ Last Full Series of X-rays? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____

Date: _____

Referral Information

Name of person or office referring you to our practice: _____

Referred to see Doctor _____

Financial Responsible Party For Payments

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street _____ City _____ State _____ Zip Code _____

Insurance Information

We do not accept insurance in our practice. We can give you a form to submit to your insurance company Or as a courtesy we can submit electronic claims for you. If you would like us to process the claim then please complete this section.

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____

Insured's Employer Name: _____

Address: _____
Street _____ City _____ State _____ Zip Code _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

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

Signature of guarantor of payment/responsible party _____ Date: _____ Relationship to Patient: _____

I acknowledge and read the Notice of Privacy Practices Statement (HIPAA) given to me by the front desk.

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

YEARLY UPDATE:

Please review your medical history form and advise us if there has been any change in your medical status over the past year? (any changes in medications, health or otherwise) _____

Are there any changes in your personal information? (address, employment, contact information)

Date: _____
Signature of patient, parent or guardian

YEARLY UPDATE:

Please review your medical history form and advise us if there has been any change in your medical status over the past year? (any changes in medications, health or otherwise) _____

Are there any changes in your personal information? (address, employment, contact information)

Date: _____
Signature of patient, parent or guardian

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