

Patient Information

Patient Name: _____ Date: _____
 Last, First MI (Preferred Name)
 Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ EXT: _____ Cell: _____

Email: _____

Pharmacy Name & Address: _____ Phone #: _____

Whom may we thank for referring you: _____

Address: _____
 Street Apartment #
 City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Any changes to medical history since last visit? YES NO

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

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Artificial Joints/Pins
Plates/Hip/Knee/Etc... | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | OTHER: |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | |

• Are you currently taking any Blood Thinners (Aspirin, Baby Aspirin, Coumadin, Plavix, Xarelto, Eliquis, Etc..)? Yes No

• Are you currently taking any Bisphosphonates (Fosamax, Actonel, Boniva, Reclast, Etc....)? Yes No

• Please list any other medications you are currently taking, if taking any: _____

• Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

• Are you now under the care of a physician? Yes No

If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

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 if under 18 _____ Date: _____

Authorization/Disclosure of Medical Information to Individuals/Family Members or Entities Listed

In compliance with H.I.P.A.A. I, _____ authorize, Commack Family Dental, to release and or discuss any or all information concerning my medical care to the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Patient/Parent/Guardian (If under 18): _____ Date: _____

H.I.P.A.A

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.
Notice of Privacy Practices available upon request

Print Name of Patient: _____ Date: _____

Signature of Patient/ Parent/Guardian(if under 18): _____ Relationship: _____

INSURANCE INFORMATION

Any changes to Insurance since last visit?: Yes No

Primary

Name of Policy Holder: _____ Is policy holder a patient? Yes No

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

Social Security Number of Policy Holder: _____

Policy Holder's Address: _____ Street City State

Zip Code

Policy Holder's Employer Name: _____

Address: _____ Street City State

Zip Code

Patient's relationship to Policy Holder: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Policy Holder: _____ Is policy holder a patient? Yes No

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

Social Security Number of Policy Holder: _____

Policy holder's Address: _____ Street City State

Zip Code

Policy Holder's Employer Name: _____

Address: _____ Street City State

Zip Code

Patient's relationship to Policy Holder: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Practice Policies & Consent

1: The undersigned hereby authorizes the doctors to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate in order to make a thorough diagnosis of the patients dental needs.

2: I also authorize the doctors to perform all recommended treatment mutually agreed upon by me and to use the appropriate medications and/or therapy indicated for such treatment in connection with the undersigned patient. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize an consent that the doctors choose and employ such assistance as deemed fit to provide recommended treatment.

3: I understand that I assume all responsibility for the payment of the dental services provided in this office for myself or my dependents, due and payable ***AT THE TIME SERVICES ARE RENDERED*** unless other arrangements have been made. In the event payments are not received by the agreed upon dates. I also understand that a finance/billing charge may be added to my account, in addition to any collection charges.

4: ***PAYMENT IS DUE AT THE TIME OF SERVICE***: We accept cash, MOST major credit cards and personal checks.

5: I understand that it is my responsibility to advice your office of any changes within my health history or insurance policy.

6: I authorize and understand that I will need to provide the office with personal information that can be used to file my dental claims.

7: I understand that I will be charged a minimum of ***\$50.00 for ANY cancelled, missed or no show appointments without notifying the office within 24 business hours.***

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

Print name of patient _____ Date: _____

Signature of patient/parent or guardian if under 18 _____ Relationship to Patient: _____