Patient Information

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

Social Security #: _____ Birth Date: _____

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

Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Pharmacy Name & Address: _____ Phone #: _____

Whom may we thank for referring you: _____

Health Information

Date of Last Dental Visit: _____ Date of last dental xrays: _____ Reason for this visit: _____

Former Dentist: _____ Phone number: _____

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

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

OTHER:
- ☐ _____

- 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.

_____ Date: _____
Signature of patient, parent or guardian if under 18

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
Last First MI

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

Policy holder's Birth Date: _____ ID #: _____ 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.

_____ Date: _____
Print name of patient

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