Patient Information

Patient Name: _____ Date: _____
First Last MI (**Preferred Name**)

Gender: _____ Family Status: _____ SSN#: _____ Birth Date: _____

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

Address: _____ Email _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for This Visit: _____

Please check all those that apply:

- ☐ AIDS/HIV
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints/Knee/Hip Replacement
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaw Joint Problems
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Pregnancy Due Date: _____
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Herbal Supplements
- ☐ Codeine Allergy
- ☐ **Latex Allergy**
- ☐ Penicillin Allergy
- ☐ Smoking
- ☐ Osteoporosis
- ☐ OTHER: please list _____

- Do you need to take an antibiotic (pre-medicate) prior to a dental visit? ☐ Yes ☐ No
- 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
- Name of Physician: _____ Phone: _____
- Please list current medications you may be taking: _____
- 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

Name of person or office who referred you to our practice: _____

SEE SECOND PAGE →

Spouse or Responsible Party Information

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

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

SSN #: _____ 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

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

Last First MI

Insured's Birth Date: _____ ID#: _____ Group#: _____

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 and Office Policy

The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

The undersigned hereby authorizes the doctor to use photographs for clinical information usage for study club or lecture or patient consultation information as long as privacy and anonynimity is protected.

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 cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

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 11/2% 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 estimation listed for this dental care can only be extended for a period of six months from the date of the patient examination and diagnosis.

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 said services shall be as billed unless objected to, by me, in writing, within the time of 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 attorney fees if suit be instituted hereunder.

For our office to furnish the best possible dental care at a reasonable cost, it is necessary that you notify our office at least 24 hours in advance of any scheduled appointment, if a change is needed. Failure to do so will make it necessary for you to be billed for the unused time reserved.

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

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____

Signature of doctor

GENERAL DENTISTRY CONSENT FORM

Printable copies of this consent form are available in the Members Only section of the NYSDA Website- www.nysdental.org, under "Member Resources"

Dentist:_____ Patient:_____

Dentistry is not an exact science and reputable practitioners cannot properly guarantee results. Despite the most diligent care and precaution, unanticipated complications or unintended results, although rare, may occur. A treatment plan is based on the best evidence available during the examination. There is no guarantee that this plan will not change. During treatment, it may be necessary to change or add procedures because of conditions that were not evident during examination, but were found during the course of treatment. For example, root canal treatment may be needed during routine restorative procedures. Any change in treatment plan may result in additional fees.

Guarantees and assurances cannot be made by anyone regarding the dental treatment which you have requested and authorized. It is essential that you keep your appointments and cooperate in your treatment to help insure the best possible result. Please read the following and initial and sign where noted.

1. FILLINGS
Care must be exercised in chewing on filled teeth, especially on large fillings and during the first 24 hours, to avoid breakage. A more extensive restorative procedure than originally diagnosed may be necessary, due to more decay than anticipated. Sensitivity can occur following a newly placed filling and will usually go away with time.
(Initials_____)

2.CROWNS, BRIDGES AND LAMINATES
These restorations involve permanent alteration of the tooth structure. It is not always possible to match the color of the natural teeth exactly with artificial teeth. Temporary restorations may come off easily. Care must be taken to insure that they are kept on until the permanent restorations are delivered. The final opportunity to make changes to the new crowns, bridges or laminates (including the shape, fit, size and color) will be before cementation. It is necessary to keep the appointment for permanent cementation. Excessive delays may allow for tooth movement, necessitating the remaking of the restoration and additional charges may be incurred.
(Initials_____)

3. DENTURES (FULL AND PARTIAL)
The wearing of dentures can be difficult. Sore spots, altered speech And difficulty in eating are common problems. Due to jaw ridge loss, retention of full dentures can be a problem. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later (this is not included in the denture fee). You are responsible to return for delivery of the dentures. Failure to do so may result in poorly fitting dentures and remakes will require additional charges. Failure to wear partial dentures every day will likely lead to tooth movement, resulting in a partial that no longer fits.
(Initials_____)

4. PERIODONTAL DISEASE
Periodontal disease affects the gums and bone which support the teeth. It is a serious, progressive infection, causing breakdown of the gums and bone and eventual loss of teeth. It is best treated in its early stage. Treatment options may include gum surgery, extractions and replacements. Undertaking any dental procedure may have a future adverse effect on the periodontia.
(Initials_____)

5. ENDODONTIC TREATMENT (ROOT CANAL)
Although over 90% effective, there is no guarantee that root canal treatment will succeed and complications can occur from the treatment. Endodontic files and reamers are very fine in instruments and separate during use. Additional surgical procedures may be necessary following root canal treatment. Despite all efforts to Save it, the tooth may still be lost.
(Initial_____)

6. REMOVAL OF TEETH (EXTRACTIONS)
Teeth may need to be extracted for various reasons, such as restorability, lack of bone support, part of orthodontic treatment, impactions, etc. There are alternatives to the removal of treatable teeth and these options include root canal treatment, periodontal treatment and crowns. Removal of teeth does not always remove the infection present, and further treatment may be necessary. There are complications involved in having teeth removed, including but not limited to swelling, spread of infection, dry socket, loss of feeling in the teeth, tongue and surrounding tissues (which is usually Temporary, but in cases in permanent), sinus involvement and jaw fracture . If complications arise during or following treatment, referral to a specialist may be needed, requiring further treatment and additional costs.
(Initials_____)

7. DRUGS, MEDICATIONS AND ANESTHETICS
Antibiotic, analgesics, natural supplements and other medications can cause allergic reactions such as redness and swelling of tissue pain, itching, vomiting and/or anaphylactic shock. Injections of anesthetics can cause paresthesia (numbness) of teeth, lips and surrounding tissues. Though quite rare, this numbness can sometime be permanent. Studies have shown that Bisphosphonate (therapy for osteoporosis) can compromise treatment results.
(Initials_____)

Signature of Patient_____ Date_____

Signature of Dentist _____Date_____

JOEL HELLER, D.M.D.
282A SUNRISE HIGHWAY
ROCKVILLE CENTRE, NY 11570
(516) 764-6339

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name:_____ Date:_____

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may evoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

  The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures and my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy on request.

Signature_____ Date:_____

Relationship to patient (if signed by a personal representative of patient):_____