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:

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

- 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.

_____ Date: _____
Signature of patient, parent or guardian

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

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 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.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

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

_____ Date: _____ Relationship to Patient: _____

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

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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