Please complete all information – Thank you!

Patient name: First:___________________Last:_________________________ Date of birth______________

DENTAL HISTORY

Reason for today's visit____ Date of last dental visit_________________________

General dentist____ Date of last dental x-rays_________________________

Please check if you ever have/had:

	Yes	No
Bad breath	☐	☐
Blisters on lips or mouth	☐	☐
Buming sensation in tongue	☐	☐
Chew on one side of mouth	☐	☐
Cigarette, pipe or cigar smoking	☐	☐
Smokeless tobacco	☐	☐
Dry mouth	☐	☐
Food collection between teeth	☐	☐
Teeth grows or sore spots in your mouth	☐	☐
Gums swollen or bleeding	☐	☐

	Yes	No
Head, neck, jaw pain or arches	☐	☐
Lip or cheek biting	☐	☐
Loose teeth or broken fillings	☐	☐
Mouth breathing	☐	☐
Orthodontic treatment	☐	☐
Periodontal treatment	☐	☐
Sensitivity to pressure or irritants (cold, heat, sweet)	☐	☐

How often do you floss?_____________

How often do you brush?____________

Have you ever had an allergic reaction to Novocaine, local or general anesthetics? Yes No

If Yes, please explain___________________________

____

____

Have you ever had trouble from previous dental care? Yes No

If Yes, please explain___________________________

____

____

MEDICAL HISTORY

Physician's name______________________Date of last visit__________Physician's address_____________________________

Have you ever had any serious illnesses or operations? Yes No If Yes, please describe_____________________________

Have you ever had a blood transfusion? Yes No If Yes, give approximate dates_____________________________

Women only: Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Please check if you ever have/had:

	Yes	No
Allergies, hay fever, sinusitis	☐	☐
Anemia	☐	☐
Arthritis, Rheumatism	☐	☐
Artificial heart valves	☐	☐
Artificial joints	☐	☐
Asthma	☐	☐
Required hospitalization	☐	☐
Have you used steroids	☐	☐
Date of last episode__________		
Bleeding abnormally with operations or surgery	☐	☐
Blood disease, clotting disorders	☐	☐
Cancer	☐	☐
Chemical dependency	☐	☐
Chemotherapy	☐	☐
Circulatory problems	☐	☐
Cortisone treatment	☐	☐
Cough, persistent or bloody	☐	☐
Diabetes	☐	☐
Emphysemia	☐	☐
Epilepsy	☐	☐
Fainting	☐	☐
Glaucoma	☐	☐

	Yes	No
Headaches	☐	☐
Heart murmur	☐	☐
Heart problems	☐	☐
Hepatitis type______	☐	☐
Herpes	☐	☐
High blood pressure	☐	☐
HIV	☐	☐
Any immune deficiency	☐	☐
Jaundice	☐	☐
Kidney disease	☐	☐
Low blood pressure	☐	☐
Mitral valve prolapsed	☐	☐
Osteoporosis	☐	☐
Osteopenia	☐	☐
Pacemaker	☐	☐
Radiation treatment	☐	☐
Respiratory disease	☐	☐
Rheumatic fever	☐	☐
Scarlet fever	☐	☐
Shortness of breath	☐	☐
Sinus trouble	☐	☐
Sickle cell anemia	☐	☐
Skin rash	☐	☐

	Yes	No
Slow healing wounds	☐	☐
Stroke	☐	☐
Swelling of feet or ankles	☐	☐
Thyroid problems	☐	☐
Tonsillitis	☐	☐
Tuberculosis	☐	☐
Tumor or growth on head/neck	☐	☐
Ulcer	☐	☐
Venereal disease	☐	☐
Weight loss, unexplained	☐	☐
Do you wear contact lenses?	☐	☐
Do you consume alcoholic beverages?	☐	☐
Are you allergic/sensitive to Latex?	☐	☐
Allergic to Penicillin, Aspirin or other drugs?	☐	☐

If Yes, please specify________________________________

____

____

List any medication that you are taking:________________

____

____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian signature____ Date ________________________________

Reviewed by:____ Date________________________________

Park Avenue Oral Surgery

PATIENT INFORMATION

Last Name First Name Middle Initial

Date of Birth Social Security Number Gender: Male Female

Home Address Apt # City State Zip Code

Home Phone Other Phone □Cell Work Marital Status

Email Address

Dental Insurance Name and Policy #

Employment Status: ☐ Full ☐ Part ☐ Not Employed ☐ Student ☐ Other Employer

Referred By: ____

Pharmacy (name and phone number): ____

EMERGENCY INFORMATION

Last Name First Name Relationship to Patient

Home Phone Work Phone Other Phone

INSURANCE POLICY HOLDER INFORMATION

Relationship to Patient □Self □Spouse □Parent □Other

Last Name First Name

Date of Birth Social Security Number Gender: Male Female

Home Address Apt # City State Zip Code

Home Phone Other Phone □Cell Work

Employment Status: ☐ Full ☐ Part ☐ Not Employed ☐ Student ☐ Other Employer

THE US HEALTH RESOURCES & SERVICES ADMINISTRATION ASKS FOR THE FOLLOWING:

Race: □Black/African American □American Indian/Alaskan Native □ Asian □ Native Hawaiian □ Other Pacific Islander □White

Ethnicity: Hispanic/Latino □ YES □ NO **Language best served:**

Homeless: □YES □NO **Veteran:** □YES □NO **Migrant/Agricultural Worker:** □YES □NO

Blind: □YES □NO **Deaf:** □YES □NO **U.S. Citizen:** □YES □NO

Financial Policy

Payment is due at the time of your appointment. You may pay by check, cash, Mastercard or Visa.

We will file for covered services for all insurance plans in which we participate. If you are covered by insurance, you will need to be prepared to pay your deductible and any co-payments at the time of your appointment. You will also need to have your complete insurance information with you.

Please contact your insurance carrier for your benefit information and whether or not services will be covered in our office. Please call your insurance company if you have any questions about your benefits. It is also important to note that some procedures will be covered under your medical insurance, while others are covered under dental insurance.

Any balance on your account not paid by your insurance carrier within 30 days will become your responsibility and payment will be due from you. We do all we can to provide pertinent medical/dental information on your claim. Please contact the customer service representative of your insurance plan if you are dissatisfied with your claim denial and feel your service should be covered.

If your account is unpaid within 45 days from the date of service, it will be sent to a collections agency with a 50% collections fee added.

Cash Patients

If you are unable to pay your bill in full at the time service is rendered we will be happy to arrange financing for you or create a customized payment plan allowing you to pay your full bill within one year. Please do not hesitate to ask us to set this up for you. If you are to have surgery under general anesthesia (asleep), we do require that you pay a down payment of $500 by the date of your surgery.
If you have any questions about our financial policy, please call us at 212 644-7009. Our staff is always willing to assist you.

Cancellation Policy

Appointments that are missed or cancelled with less than 24 hours notice not only prevent you from receiving care but also prevent others from being able to receive care at that time. For this reason such cancellations or missed appointments will result in a fee of $50. If your appointment was for a procedure under general anesthesia, the fee will be $200. This fee may be waived if the reason for cancellation is beyond the control of the patient.

Collections and Legal Fees
If it becomes necessary for an account to be turned over to an attorney or collections agency the costs of such action will be the responsibility of the patient.

______________________________________ _______________
Patient/Parent or Legal Guardian Date

PATIENT CONSENT FORM
(HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
2. Obtaining payment from third party payers (e.g. my insurance company)
3. The day to day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this __________ day of ___________________________, 2017
Print Patient Name: ____
Relationship to Patient: _______________________________________
Signature: ____