Stuyvesant Dental Associates, PC

Patient Information (confidential)

Patient's Name_____ Sex [ ] Male [ ] Female
LAST **First** **Middle**

E-Mail Address _____ Home Phone_____

Cell Phone _____ Work Phone _____

Date of Birth: _____ Whom may we thank for referring you?_____

Address_____APT_____City_____State_____Zip_____

Emergency contact name_____Phone_____

Insurance Information

What is the patient's relationship to the insured party? [ ]Self [ ]Spouse [ ]Child [ ]Other _____

Name of insured party _____Address _____

Insured's Social Security # _____ Insurance ID # _____

Insured's date of birth _____

Insured's Employer_____Business Phone _____

Insurance Company_____Group # _____

If you have more than one insurance policy, please complete the next section.

What is the patient's relationship to the insured party? [ ]Self [ ]Spouse [ ]Child [ ]Other _____

Name of insured party _____Address _____

Insured's Social Security # and insurance ID # _____

Insured's date of birth _____

Insured's Employer_____Business Phone _____

Insurance Company_____Group # _____

STUYVESANT DENTAL ASSOCIATES. P.C.

Confidential Dental Health History

Patient Name_____Birthdate_____

Reason for today's visit_____

Date of last dental exam_____Date of last x-rays_____

Put a check in the box if you have had problems with any of the following:

□ Bad breath	□ Grinding teeth	□ Sensitivity to hot
□ Bleeding gums	□ Loose teeth or broken fillings	□ Sensitivity to cold
□ Clicking or popping jaw	□ Periodontal treatment	□Sensitivity when biting
□ Food collection between teeth	□ Sores or growths in your mouth	□ Sensitivity to sweets

How often do you floss?_____How often do you brush? _____

Medical History

Physician's Name_____Date of last visit_____
Have you had any serious illnesses or operations?_____If yes, describe_____
_____

WOMEN: Is there a possibility that you are pregnant? □ Yes □ No
Are you nursing? □ Yes □ No
Are you taking birth control pills? □ Yes □ No

Please check the box if you have or have had any of the following:

□ AIDS/HIV positive	□ Cortisone treatments	□ Hepatitis
□ Anemia	□ High Blood Pressure	□ Arthritis
□ Artificial Heart valves	□ Diabetes	□ Ulcer
□ Artificial joints	□ Epilepsy	□ Kidney disease
□ Stroke	□ Asthma	□ Fainting
□ Liver Disease	□ Hemophilia	□ Blood Disease
□ Headaches	□ Nervous Problems	□ Cancer
□ Pacemaker	□ Tonsillitis	□ Chemotherapy
□ Heart Problems	□ RadiationTreatment	□ Tuberculosis

Medications:

List medications you are currently taking:

_____
_____
_____
_____

Drug Allergies:

□ Aspirin	□ Penicillin
□ Barbiturates (sleeping pills)	□ Sulfa
□ Local anesthetic	□ Codeine
□ Other_____	□ Foods

By signing below, I acknowledge that I have truthfully answered the above questions.

Patient's Signature_____ Date _____

Reviewed by_____Date _____

STUYVESANT DENTAL ASSOCIATES. P.C.

Financial Responsibility

Today's Date: _____

Patient Name:_____

Responsible party if other than patient_____

Relationship to patient: _____

The full cost of dental treatment is the responsibility of the patient or legal guardian. For patients with dental insurance, Stuyvesant Dental Associates, P.C. will extend every effort to assist you in obtaining the maximum benefit. When benefits are assigned to the practice, **your estimated out-of-pocket expenses are due on the day of treatment**. We agree to wait a reasonable period of time for the insurance company to pay its portion. If the insurance company fails to pay after sixty days, you agree to pay the balance due.

_____

Signature of patient or responsible party

Insurance Authorization

I have been informed of the treatment plan and the associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

I hereby authorize and direct payment of the dental benefits otherwise payable to me directly to Stuyvesant Dental Associates.

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Signature of patient or responsible party