Eastchester Dental Care, PLLC

Patient Information

Patient Name: _____ Today's Date:_____
Last, First MI

Gender: Male☐ Female☐ Marital Status: Single ☐ Married ☐ Child ☐ Student: Yes☐ No☐

Social Security #: _____ Date of Birth: _____

(Home phone): _____ (Cell): _____

(Work):_____ Ext: _____Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: The patient☐ Person responsible for payment ☐

Employer Name: _____ Occupation: _____

Address: _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

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

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ 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
- ☐ Are you currently **Pregnant** ☐ Yes ☐ No
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
☐ _____

- 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: _____
- Are you taking any medications? ☐ Yes ☐ No
  If yes, please list: _____

_____

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. **Please Initial:** _____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐ Dental Office ☐ Yellow Pages
☐ Newspaper ☐ School ☐ Work ☐ Other/name of person referring you _____

Information of Responsible Party for Payment

Name: _____
Last First ☐ Male ☐ Female

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Email Adrress:_____

Address: _____

Insurance Information

Primary

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____/___/____ Ins ID/SS #: _____/_____/_____ ___ Group #:_____

Insured's Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name & Phone# _____

Insured's Employer Name:_____

Secondary

Name of Insured: _____ Ins insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____/____/_____ Ins ID/SS #: _____/_____/_____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name & Phone#:_____

Signature of person responsible for payment:_____

Acknowledgment of receipt of Notice of Privacy Practice (HIPAA)

I,_____ received a copy of this office's Notice of Privacy Practice and Broken Appointment Policy.

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.

_____/_____ /_____
Patient's / Guardian Signature Date Relationship to Patient

1_____/_____ 3_____ /_____
Doctor's Signature Date Doctor's Signature Date

2_____/ _____ 4_____ / _____
Doctor's Signature Date Doctor's Signature Date