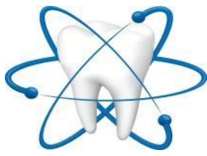

Eastern Dental Care PLLC
1140 Eastern Parkway, Brooklyn, NY 11213
info@easterndentalclinic.com
•phone: 718-221-1300 •fax: 315-825-4788

Patient Information Form

Patient's Name: ________________________________ SEX M / F DOB: ______________

Address____ Apt/Suite # ________

City ____ State ______ Zip___________

Cell Phone ____________________________ Home Phone _____________________________

Email Address ____

Social Security#: _________________________ Driver License (optional)___________________

Closest Relative ______________________________ Phone Number _______________________

Employer ___________________________________ Employer Phone ______________________

If patient is a child fill out the next part

Responsible person ___________________________ Relationship to Patient _______________

DOB: ____________________ Social Security________________________ Sex: M / F

Cell# __________________________ Home#_____________________

Address (if different from top) ____ Apt/Suite # ______

City ____ State ______ Zip_________

Insurance Information (Cross out if no insurance)

Insurance name (Primary) ____

Primary Subscriber _______________________________________ Subscriber DOB __________

ID# ____ Group # ________________

Insurance name (Secondary) ____

Secondary Subscriber _____________________________________ Subscriber DOB __________

ID# ____ Group # ________________

Dental History

Reason for Today's Visit ____
Date of last dental visit ____________________ Dentist Name: ______________________________

(This information is necessary for our files and will be considered CONFIDENTIAL)

Check if you have had problems with any of the following:

___ Bad Breath
___ Grinding teeth
___ Sensitivity to hot/cold
___ Bleeding gums
___ Loose teeth
___ Sensitivity to sweets
___ Clicking or popping jaw
___ Broken fillings
___ Sores or growths in mouth

How often do you floss? _______________________ How often do you brush? ______________________

Medical History

Are you in good health? Y N

Date of last physical examination _________________________

Are you being treated by a physician? Y N

If yes, for what? _______________________________________

Have you had history of serious illness or operation? Y N If yes, for what? _______________________________

Have you been hospitalized? Y N If yes, for what? ____

Are you currently taking any medication? ____

Are you taking any recreational drugs? ____

Have you ever been pre-medicated with antibiotics for your dental treatment? Y N

Any allergies to medication? ____

(Women) Are you pregnant? __ Yes __ No Nursing? __ Yes __ No Birth Control Pills? __ Yes __No

Check if you have or have had any of the following:

Y N Anemia	Y N Glaucoma	Y N Sleep Apnea	Y N Angina Pectoris	Y N Pain in Jaw Joints	Y N Psychiatric Treatment
Y N Herpes	Y N Tonsillitis	Y N Snoring	Y N Mental Disorder	Y N Artificial Prosthesis	Y N Hepatitis or Jaundice
Y N Stroke	Y N Hemophilia	Y N Heart Murmur	Y N Thyroid Disease	Y N Sickle Cell Disease	Y N Difficulty Swallowing
Y N Ulcer	Y N Cold Sores	Y N Liver Disease	Y N Fainting Spells	Y N Cortisone Medicine	Y N Congenital Heart Lesions
Y N Diabetes	Y N Emphysema	Y N Blood Disease	Y N Rheumatic Fever	Y N Allergies to Metals	Y N Osteoporosis
Y N Arthritis	Y N Rheumatism	Y N Heart Ailments	Y N Tuberculosis (T.B.)	Y N Excessive Bleeding	Y N X-Ray or Cobalt Treatment
Y N Asthma	Y N Chicken Pox	Y N Heart Attack	Y N Blood Transfusion	Y N Mitral Valve Prolapse	Y N Radiation Treatment
Y N Cancer	Y N Bruise Easily	Y N Cerebral Palsy	Y N Low Blood Sugar	Y N High Blood Pressure	Y N Venereal Disease
Y N Seizures	Y N Head Injuries	Y N Drug Addiction	Y N Joint Replacement	Y N Low Blood Pressure	Y N AIDS
Y N Hay Fever	Y N Heart Failure	Y N Kidney Disease	Y N Nervous Disorders	Y N HIV Related Complex	Y N TMJ Disorder
Y N Headaches	Y N Scarlet Fever	Y N Chemotherapy	Y N Tumors or Growths	Y N Respiratory Disease	
Y N Implant(s)	Y N Sinus Trouble	Y N Stomach Ulcers	Y N Allergies or Hives	Y N Epilepsy or Seizures	

Do you have any disease, conditions, or problem not listed that you think we should know about? Y N
If so, what? ____
Do you wear a cardiac pacemaker, or have you had a heart surgery? Y N
Have you ever taken the drugs (circle all that apply): Fen-Phen Redux Fosamax Zometa Actonel Boniva Aredia Diet Drugs

Patient/Guardian Signature ____ Date _____________________

Doctor Signature ____ Date _____________________

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Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major dental insurance payments, however we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.

- **Minors must be accompanied by a parent or legal guardian**. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

Payments

- **Patient portion orpatient co-pay is due atthe time services are rendered -** unless prior financial arrangements have been made.
- **If you have more than Two family member scheduling an appointment on same day**-Deposit is required

- **Payment Information:**
  - All major credit cards are accepted (Visa, MasterCard, Discover)
  - 10% Discount for our uninsured cash/check paying patients
  - Various financing options with CareCredit®

- **Balances left over 90 days will incur an 18% or $10 minimum monthly finance charge.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Short Cancelled/ Missed Appointments

- **Please give 48 hours notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.
- **If you would like to book any major procedure for Saturday Only a Refundable $45 is required.**

- **Short canceled or missed appointments** will be charged $45 for Canceled or Missed appointments.

By signing below I acknowledge I have read and understand the guidelines above.

Signature: ______________________________________ Date: ________________

(This information is necessary for our files and will be considered CONFIDENTIAL)

Medical Consent

- I agree to dental care services provided by Eastern Dental Care PLLC and Request My Dental care provider(s) to provide any care they think is necessary and consistent with my needs. I know I have a say in care I receive.
- I understand this care may include tests, examination, Image captures, X-Ray, Root canals, Extraction (removal of teeth), Crowns, fill-ins, Implants and other surgical treatments and related anesthesia. I acknowledge that no guarantee has been made to me as the results that may be obtained from this care and that I can refuse services at anytime. I understand if any special procedures or operation are needed, my dental care provider will discuss this with me and my additional consent will be required.
- I acknowledge that the health care provider(s) treating me may be independent contractors, not employed by Eastern Dental Care PLLC.
- I understand that I have the right as patient and that I will be treated with dignity and respect
- I agree Eastern Dental Care PLLC is not responsible for my personal belongings and valuables.

Text Message from North Island Dental Arts

- I understand Eastern Dental Care PLLC may contact me after my visit in order to request feedback on my experience by sms text message, which may be via automated means. I may opt-out of receiving test messages by notifying Eastern Dental Care PLLC in writing (including responding vis text.) standard telephone minutes and text messages charges may apply if nor contracted.
- While Eastern Dental Care PLLC works hard to protect your information and will only include first name and general reference to your recent Eastern Dental Care PLLC visit via Text, I understand that electronic communication is never 100% secure.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2013

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: ___________________________________ **Date:**__________________