Staten Island DENTAL GROUP

New Patient Form

979 Willowbrook Road
Staten Island, NY 10314
(718)698-1885
www.statenislanddentalgroup.com

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Information:

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Sex: □ Male □ Female Marital Status: □ Married □ Single □Divorced □ Widowed

Date of Birth: _____ Soc. Sec.: _____ Drivers Lic.: _____

Email: _____

Employment Status: □ Full Time □ Part Time □ Retired

Emergency Contact Name: _____ Emergency Contact Number: _____

Responsible Party (if someone other than the patient)

□ Responsible Party is also a policy holder for patient (□ primary insurance policy holder □ secondary insurance policy holder)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Sex: □ Male □ Female Marital Status: □ Married □ Single □Divorced □ Widowed

Date of Birth: _____ Soc. Sec.: _____ Drivers Lic.: _____

Email: _____

Does Patient have Dental Insurance: □ YES □ NO (If yes, please fill out information below)

Is the patient the policy holder? □ YES □ NO (If no, please fill out Responsible Party Section)

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: □ Self □ Spouse □Child □ Other

Insured Soc. Sec.: _____ Insured Date of Birth: _____

Employer: _____ Insurance Company: _____

Group ID: _____ Member ID: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: □ Self □ Spouse □Child □ Other

Insured Soc. Sec.: _____ Insured Date of Birth: _____

Employer: Insurance Company:

Staten Island Dental Group

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Staten Island DENTAL GROUP

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: _____

Address: _____

Telephone: _____ Email: _____

Social Security Number: _____

Section B: To the Patient – Please Read the Following Statements Carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to ready our Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr Frank DiCicco, DMD
Telephone: (718)698-1885 Fax: (718)698-8499
Address: 979 Willowbrook Road. Staten Island, NY 10314

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and Disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to the Patient: _____

Staten Island DENTAL GROUP

FINANCIAL POLICY

Payment is due at the time of treatment. We accept cash, check, and major credit cards. We also have a payment plan called CareCredit that allows you to start treatment today and spread payments over time.

Payment Options:

- Cash or Check
- Major Credit Cards
- CareCredit

Applying for CareCredit only takes a few minutes and there is no fee to apply.

Please indicate below the form of payment you choose to settle your account (check one):

- Cash or Check
- Major Credit Cards
- CareCredit (subject to credit approval) If credit application is declines, another form of payment listed above is required.

I understand that I am responsible for ALL fees regardless of insurance coverage. I agree that parents are responsible for all fees and services rendered for treatment of a child. In the event that my payments are not received, I agree to pay all costs of collection, including, but not limited to reasonable attorney's fees.

Signature of Patient/ Responsible Party: _____

Date: _____

Staten Island
DENTAL GROUP

Authorization for Signature on File
Release of Information/ Financial Responsibility/ Authorization for Payment

I, _____ and/or _____
(Name of patient/parent or guardian of minor) (Name of insured)

Hereby authorize the office of Staten Island Dental Group to add my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with _____. I hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed above. I have reviewed the treatment plan fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contracted agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relation to the claim.

This "Authorization" will be valid from this date and shall expire in one year. A photocopy of this document may act as an original.

_____ _____
(Signature of Insured) (Witnessed by)

_____ today's Date: _____
(Signature of Patient/ Parent or Guardian of Minor)

Staten Island
DENTAL GROUP

Cancellation and Broken Appointment Policy

We understand that illness, emergencies, flat tires and bad weather do occur. We ask our patients to give us 24 hours notice whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

Policy and Fees:

Cancellation or rescheduling of an appointment with 24 hours or more notification – no charge

Cancellation or rescheduling of an appointment less than 24 hours considered a broken appointment.

Failure to give 24 hour advance notice:

- We allow for one (1) broken appointment within a 12 month period
- 2nd broken appointment within a 12 month period will be charged a fee of $25
- 3rd broken appointment within a 12 month period will be charged a fee of $50

Definition of a "Broken Appointment"

A broken appointment is when you...

- Cancel or reschedule an appointment with less than 24 hours notice
- Do not show up for the scheduled appointment

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of care, as trained professionals and dental facilities are not being utilized.

We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask us.

I have read and understand the above mentioned policy.

Patient signature (Parent or Guardian if minor): _____

Date: _____