A Center for Dental Excellence

8510 Bay 16th Street

Brooklyn, N.Y. 11214

Tel: (718) 232-8289

Fax: (718) 228-7453

Dear ______________________________________,

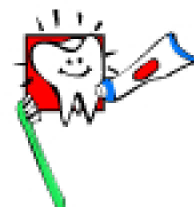
Welcome to our office!! Thank you for choosing us as your dental care provider!! We look forward to serving you. Enclosed please find our new patient packet which includes your medical history and insurance forms. Please fill out each form completely and return them to us on your scheduled appointment date. Feel free to call us with any questions you many have. We look forward to seeing you!

Date: ____________________

Time: ____________________

Sincerely Yours,

The Staff at ***A Center for Dental Excellence***



Welcome!

REGISTRATION FORM

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Section I: Patient Information

Date______________

Name:____ I Prefer to be called: _________________________
Address:____City:______________State:________Zip_______________
Phone (______)_________________ Work Phone (_____) ________________ Cell Phone (______)____________________
The best time to contact me is:_________________ ☐ A.M. ☐ P.M. On my ☐ Home phone ☐ Work phone ☐ Cell phone
Date of Birth:_______________ Social Security Number:_________________________
Check Appropriate Box: Female☐ Male☐ ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School_____________________________ City/State____________________________
Spouse or Parent's
Name________________________Employer______________Occupation_________WorkPhone____________
Whom may we thank for referring you? ____
Person to contact in case of emergency____________________________________ Phone_________________________
Email Address____ ____

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:____ Relationship to Patient: ______________________
Address:____
City:________________________________ State:__________ Zip:_____________ Phone: (____)_______________________
Employer_________________________ Work Phone (____)_________________ SSN#_____________________________

Section III Insurance Information

Name of Insured________________________________DOB_______________Relationship to Patient ________________
SSN#:________________________ Name of Employer:_______________________ Work Phone: (____)_______________
Address of Employer:___________________________________City_________________State:________Zip ___________
Insurance Company_____________________________ Group #______________________
ID#_________________________
Ins Co Address:____ Ins Co. Phone:_____________________________

DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ------------

Name of Insured________________________________DOB_______________Relationship to Patient ________________
SSN#:________________________ Name of Employer:_______________________ Work Phone: (____)_______________
Address of Employer:___________________________________City_________________State:________Zip ___________
Insurance Company_____________________________ Grp #_____________________ ID#_________________________
Ins Co Address:____ Ins Co. Phone:___________________________

Medical Information

Name of Insured______________ SS# _____________________Birthday___________
Relationship to Patient: Self _________Spouse _______Child ________Other ____Date Employed_______
Name of Employer_____________ ____Work Phone (___) ________
Address_______________ City ______________ State ____ Zip_____
Insurance Co. ______________ Group #__________ Employer #__________

Dental History

Personal Information

Former Dentist:	Date of Last Dental X-Rays & Exam:
Reason for today's visit:	

Check any of the following that apply to you:

O Bad Breath	O Grinding Teeth	O Sensitivity to Hot
O Bleeding Gum	O Loose or Broken Fillings	O Sensitivity to Sweets
O Clicking or popping jaw	O Periodontal Treatment	O Sensitivity when Biting
O Food Collection between teeth	O Sensitivity to Cold	O Sores or Growths in your Mouth

Medical History:

Physician: ___________________________ Date of Last Medical Exam__________

Allergies:__________________________

Chronic Illnesses

O AIDS	O Cough, Persistent	O High Blood Pressure
O Anemia	O Cough up Blood	O HIV Positive
O Arthritis, Rheumatism	O Diabetes	O Jaw Pain
O Artificial Heart Valves	O Epilepsy	O Kidney Disease
O Asthma	O Excessive Bleeding	O Liver Disease
O Back Problems	O Fainting	O Mitral Valve Prolapse
O Bleeding Abnormally	O Glaucoma	O Nervous Problem
O Blood Disease	O Headaches	O Pacemaker
O Cancer	O Heart Problems	O Penicillin Allergy
O Chemical Dependency	Describe______________	O Psychiatric Care
O Circulatory Problem	O Hemophilia	O Radiation Treatment
O Congenital Heart Lesions	O Hepatitis	O Respiratory Disease
O Cortisone Treatments	O Hernia Repair	O Rheumatic Fever
O Scarlet Fever	O Shortness of Breath	O Skin Rash
O Stroke	O Swelling of Feet or Ankles	O Smoking Habit
O Thyroid Problems	O Tonsillitis	O Tuberculosis
O Ulcer		O Venereal Disease

Please List Any Current Medications You are Taking:

O None O Unknown ____

____

Certification and Assignment:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with (name of insurance company)___________________________ And assign directly to Dr.______________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payments for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is complete one year from the date signed below:

Signature of Patient , Parent, Guardian or Personal Representative____ Date________

Please Print name of Patient, Parent, Guardian or Personal Representative____Date________

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Acknowledgement of Receipt of Notice of Privacy Practices and Office Financial Policy Statement

The Health Insurance Portability and Accountability Act of 1996 requires that health care providers give patients a copy of the office notice of privacy practices and makes a good faith effort to obtain an acknowledgement of receipt of same. You may refuse to sign this form.

By signing this form, I confirm that I have received the following:

A) A copy of the office privacy policy was made available
B) A Copy of the office financial policy is available at the front desk

Print Name____

Signature____

Date____

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Our Financial Arrangement Policy

We feel the best thing about our style of dentistry is our commitment to quality. If you've been in our practice a while, you already know our attention to detail and fine materials is second nature to us. But everyone's financial situation is different. And good dentistry won't count for much if it's beyond your means. So we'll find a way!

Once a treatment plan has been established, you'll receive a complete description of the treatment needed and an estimate. Our administrative staff will be happy to help you choose from several payment options.

Dental Insurance

Although we work with most dental insurers, we can make **no guarantee** of any estimated coverage. **Because the insurance policy is an agreement between you and the insurance company, we ask that all patients be directly responsible for all charges.** Please know that we will do everything possible to see that you receive the full benefits of your policy. **If for some reason your insurance company has not paid their portion within 60 days from the date of treatment, you are responsible for payment at that time.**

Payment Options

- **Cash or Check**: We are happy to offer a 5% pre-payment courtesy for all treatment paid in full prior to treatment.
- **Credit Cards:** For your convenience, we accept MasterCard, Visa, American Express and Discover.
- **Payment Plans:** For patients who desire a monthly payment plan, we have made arrangements with several finance companies. There are no application fees, no down payment, and the loan can be interest free. Applications are available from the front desk staff and approval is provided quickly.

Our goal with each of you, our patients, is to help you enjoy the benefits of good oral health. With proper care, you will be able to have strong teeth and gums, a healthy and attractive smile, and keep your own teeth for a lifetime.

Patient Signature____Date__________