

DENTAL REGISTRATION AND HISTORY

1

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name _____
First Name _____ Middle Initial _____

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ 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 dentist 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 payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

X
Signature of Patient, Parent, Guardian or Personal Representative

X
Please print name of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship to Patient _____

3

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4

DENTAL HISTORY

Reason for today's visit _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	

5

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No

Due date _____

Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone (____) _____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

6

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ARDEN DENTAL SERVICES, P.C
2610 OCEAN PARKWAY
BROOKLYN, NY 11235

HIPAA PRIVACY FORM
Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

I, _____, have received a copy/explanation of this office's Notice of Privacy Practices.

{Signature of Patient and/or Guardian}

{Date} _____

(Relationship to Patient) Self

or Other: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers (such as a language barrier) prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement at time of service
- ☐ Other (Please specify)

Our Financial Alliance Philosophy

Our goal in discussing financial arrangements with you is no surprises for our patients. We want a complete understanding and partnership in the settlement of your account.

It is important to us that the quality of our business services matches the quality of our dentistry. We want the handling of your account, from the start through final payments to be perceived as an extension of the dental care we provide you and your family. Is that also what you want? **We believe that no dental problem should ever become a financial burden.**

Patient's Role

As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment at time of service. Our team will work with you to determine financial arrangements that make sense for both of us.

In developing a financial arrangement it is important to remember your dental future. Our experience has shown that when an account lingers, patients are likely to defer their appointments. It is discouraging to add new charges to an account when trying to pay off old charges. With this in mind, we will concentrate our efforts on clearing your account in as short a time (90 days, unless other arrangements were made).

Thank you in advance for completing our paperwork for your total care health and dental histories and insurance information prior to you seeing **Dr.PAVLOV**

THERE IS A BROKEN APPOINTMENT FEE OF \$30 (30min appointment) and \$100 (1 hour appointment)

WE ACCEPT CASH, CHECKS OR MASTERCARD, VISA or WE OFFER ACCESS TO EASY PAY OPTIONS LIKE EXTENDED PAYMENT PLANS (CARE CREDIT) WITH CREDIT APPROVAL

Regarding Insurance

We may accept assignment of insurance benefits, however the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you. That balance will be due upon billing. We very much appreciate your payment upon receipt of services. In the event that your insurance company denies payment of a service, you are responsible for that fee. Any unpaid balance after insurance pays is due within 45 days.

Please provide permission to process your credit card for any portion not covered by insurance or remaining balance not paid within 45 days after insurance payment is received.

Card Number: _____ Exp. Date: _____

Name on Card _____

Patient Signature _____

I understand that any unpaid balance after 60 days is charged a yearly finance charge of 18%. I further understand that this finance charge is equal to 1.5% of my outstanding balance per month. **I understand that if my account reaches collection status (180 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney. If ARDEN DENTAL SERVICES must take additional steps to collect my account, I will pay ALL cost of collection, including court cost and attorney's fees incurred by them.**

Thank you for reading our Financial Alliance. Please let us know if you have any questions or concerns. I have read the Financial Alliance. I understand, accept, and agree to this Financial Alliance.

Signature of Patient or Responsible Party _____

Date _____

COVID-19 PANDEMIC - PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Have you had a fever or above normal temperature?	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced shortness of breath or had trouble breathing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a dry cough?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a runny nose?	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently lost or had a reduction in your sense of smell or taste?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have you had a sore throat?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in contact with someone who has tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
Have you tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been tested for COVID-19 and are awaiting results?	<input type="checkbox"/>	<input type="checkbox"/>

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Signature

Date

Witness