Robert D Lipschutz, DMD, PC
General & Cosmetic Dentistry

<PERSONAL INFORMATION>

Name _____

Address street _____ apt# _____ Phone Number _____
City _____ State _____ Zip _____ E-mail _____

Employer (School)
Address street _____ apt# _____ Phone Number _____
City _____ State _____ Zip code _____

Date of Birth _____

Social Security #_____

Please circle : single married

How did you hear about us? _____

<INSURANCE INFORMATION>

Insurance Company _____
Address street _____ apt# _____ Phone Number _____
City _____ State _____ Zip code _____
Group/Policy Number _____

If you are a dependant:
Beneficiary's name _____
Employer: _____
Phone number: _____
Social Security Number: _____
Relationship to beneficiary: _____

- continued-

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<DENTAL HISTORY>

Are you in pain now? _____
What would you like attended to today? _____
Purpose of your last dental visit and date _____
When did you have your last full set of x-rays taken? _____
Did you ever experience any difficulty or complication following dental treatment? Explain.
_____

Which of the following best describes your feeling about going to the dentist?
I am usually relaxed about it I am somewhat uneasy I am extremely nervous

<MEDICAL HISTORY>

Please be assured that the information requested for your health record and treatment will be kept strictly confidential.

Height_____ Weight_____
Physician's name _____
Physician's address_____
Date and nature of last visit _____
Other healthcare providers you have consulted in the last 2 years other than dentists. Explain.
_____
Are you currently taking any medication?_____
Have you ever had a bad reaction to any medication?_____
Do you have any allergies? _____
Have you ever been seriously injured or hospitalized?_____
Have you ever had surgery?_____
Have you ever been treated orthopedically for any reason?_____
Have you ever received radiation therapy?_____
If you are a woman, are you pregnant? _____
Do you smoke? How much?_____

Do you have or have you ever had any of the following (please circle):

AIDS/ARC (AIDS Related Complex)
Arthritis
Asthma
Blood or bleeding abnormality
Bone or skeletal disease
Cancer or tumor
Circulatory problems
Colds(frequent)
Congenital defect
Covid-19
Diabetes
Dizziness or fainting spells
Epilepsy
Eye, ear, nose or throat problems
Gastro-intestinal or stomach disorder
Heart murmur disease or defect
Hepatitis, liver disease
High or low blood pressure
Hormonal or endocrine imbalance
Kidney disease
Migraine or tension headache
Neurological disorder
Postnasal drip
Psychiatric problems
Respiratory disease
Rheumatic fever
Sinusitis
Thyroid disease
Ulcer
Venereal disease

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OFFICE POLICY

PAYMENTS

For your visit today, and all future visits, your balance is expected to be paid in full at the time treatment is rendered unless other arrangements have been made in writing. Please feel free to discuss financial matters with the doctor, including the cost of today's services and that of any future treatment if you have not been so advised. We offer flexible methods for extending payments over time and offer a number of different discount options if you are on a limited budget. We accept cash, checks and all major credit cards. In the event that your check is returned for insufficient funds or other reason, there will be an administrative fee.

Any estimate given as to what your insurance will pay is not a guarantee. Although we take assignment of benefits under certain conditions, you will be responsible for the difference between our fee and the insurance payments we receive on your behalf. Our office cannot know all the limitations and exclusions of every dental insurance plan nor shall it take responsibility for payments denied by your carrier based on the provisions of your policy.

APPOINTMENTS

Your dental treatment requires a sincere commitment on your part and substantial advance preparation on ours. Reserved time for your appointment is time denied to another patient. If there is a possibility that work or personal matters may conflict with the fulfillment of your appointment obligation, it is suggested, in fairness to all, that you try to be worked in on a same day as your availability and ours permits, rather than reserve time in advance.

If you cancel an appointment with less than 24 hours prior notice, you will be charged **$75** for each hour of reserved time. Notice must be given during the hours of 9:00am to 6:00pm Tuesday through Saturday. Messages left on our answering machine or sent via e-mail before or after business hours, do not constitute adequate notice. However, there will be no charge if your appointment can be reassigned to another patient or if you are able to fill another open time in our schedule, should it be available that same day. IF you are late for an appointment by more than 20 minutes, it may not be possible to treat you that visit and you will be charged the same as if it were a cancellation. In the event that you break your appointment without calling to advise us at all, the fee is $75 for each hour reserved. These fees will be billed to you and are not covered by dental insurance. Repeated appointment failures may result in dismissal from our practice.

GUARANTEES

Our office prides itself in the quality of care we have provided to our dental patients. In spite of our commitment to excellence, as with any of the health professions or healing arts, no guarantees are given or implied. Occasionally, unforeseen complications arise. Treatment outcomes may not meet the expectations of every patient. However, we will inform you in advance of the benefits, risks, and limitations of treatment, address your concerns, and try to achieve the best result we can.

I understand and accept your office policy as stated above and agree to abide by its terms as a condition to my dental treatment.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

57 West 57th Street, Suite705, New York, NY 10019 | Tel: 212-752-3001 | Fax: 212-752-3009 | E-mail: info@drlipschutz.com

Patient Screening Form

ADA.

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	**Date:**
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.