

## Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name)

Gender: \_\_\_\_\_ Family Status: \_\_\_\_\_

Social Security \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Preferred appointment times:  Morning  Afternoon  Evening  Any Time  M  T  W  T  F  S

Address: \_\_\_\_\_  
Street Apartment #

City State Zip Code

## Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

### Have you ever had any of the following? Please check those that apply:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> AIDS              | <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Allergies _____   | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Growths             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> <b>Pregnancy</b>     | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Head Injuries       | Due date: _____                               | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Respiratory Problems | OTHER:                                      |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism           | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Sinus Problems       |   |
|  | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Stomach Problems     |   |

• Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Are you now under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

• Do you have any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_

## Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative

Dental Office  Yellow Pages  Newspaper  School  Work  Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

### Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment

Name: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ Apartment # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

### Insurance Information

#### Primary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Last First MI

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

#### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Last First MI

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

### Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature of guarantor of payment/responsible party \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## GENERAL DENTISTRY

CHART NUMBER \_\_\_\_\_

NAME \_\_\_\_\_

### WORK TO BE DONE

I understand that I am having the following work done: Fillings \_\_\_\_\_, Bridges \_\_\_\_\_,  
Crowns \_\_\_\_\_, Extractions \_\_\_\_\_, Impacted teeth removed \_\_\_\_\_, I.V. Sedation \_\_\_\_\_,  
Root Canal \_\_\_\_\_, Other \_\_\_\_\_. Initials \_\_\_\_\_

### DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reaction causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

### REMOVAL OF TEETH

Alternative to removal have been explained to me (root canal therapy, crown, and periodontal surgery, etc.) and I authorized the Dentist to remove the following teeth \_\_\_\_\_ and any other necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can hurt for an indefinite period of time (days or month) or fractured jaw, I understand I may need further treatment by specialist or even hospitalization if complications occur during or following treatment the cost of which is my responsibility.

(Initials \_\_\_\_\_)

### CROWNS, BRIDGES AND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with unnatural tooth color. I further understand that I may be wearing a temporary crowns, which may come off easily and that I must be careful to ensure that they be kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crowns, and caps (including shape, bite, size and color) will be before cementation. (Initials \_\_\_\_\_)

### DENTURES- COMPLETE OR PARTIAL

I understand that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me including loosening, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, bit, size, placement, and color) will be the "teeth in wax" try-in visits. I understand that most dentures require relining approximately there to twelve months after placement. The cost for this procedure is included in the initial denture. (Initials \_\_\_\_\_)

### ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extended through the root which does not necessary following root canal treatment (pulpectomy). (Initials \_\_\_\_\_)

### PERIODONTAL LOSS (TISSUE & BONE)

I understand that I have a periodontal condition, involving gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement and/or extractions. I understand that undertaking any dental procedures may have future adverse effect on my periodontal condition.

(Initials \_\_\_\_\_)

I understand that dentistry is not exact science and that therefore reputable practitioners cannot properly guarantee results. I know that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and Please also note that as provided in **Dmitriy Volotsenko D.D.S.**'s Notice Practices, **Dmitriy Volotsenko D.D.S.** reserves the right to change the privacy practices that are described in such notice. I may obtain a revised notice of privacy practices by accessing the **Dmitriy Volotsenko D.D.S.**'s website, calling the office at 718-872-0460 and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Date