

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender _____ Married: _____ Single _____ Other: _____ Birth Date: _____

Social Security #: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Email Address: _____

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"/> Pregnancy | <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 | |

• Do you take Aspirin, Coumadin, Plavix or any blood thinners? Yes No
List: _____

Do you take Fosamax, Boniva, Actonel, Zometa or any medications for osteoporosis? Yes No List: _____

Do you require antibiotic prophylaxis prior to dental procedures (for heart murmur, Mitral valve prolapse, joint replacements or any other reason)? Yes No

Please List All Medications taken: _____

• Are you now under the care of a physician? Yes No

• 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.

X _____ Date: _____
Signature of patient, parent or guardian

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): _____ (Cell): _____
Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information

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

Employer Name: _____ Occupation: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____ Phone _____

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.

X
X

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

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

PATIENT HIPAA AWARENESS

With my permission, Beautiful Smiles of Long Island PLLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Beautiful Smiles of Long Island PLLC Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Beautiful Smiles of Long Island PLLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Beautiful Smiles of Long Island PLLC may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Beautiful Smiles of Long Island PLLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and or Confidential.

With my permission, the office of Beautiful Smiles of Long Island PLLC may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Beautiful Smiles of Long Island PLLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Beautiful Smiles of Long Island PLLC to use and disclosure my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

Date

AUTHORIZATION FORM FOR RELEASE OF INFORMATION TO FAMILY MEMBER /FRIEND

I, _____, give permission to my dental care provider to disclose and release my complete protected health/ dental information (Including but not limited to diagnosis, treatment and billing) described below to:

Name(s):

Relationship:

**BEAUTIFUL SMILES OF LONG ISLAND ACKNOWLEDGEMENT AND
CONSENT OF RECEIPT OF OFFICE PROCEDURES**

All co-payments and deductibles are due at the time of visit, unless prior arrangements have been made with the Office Manager.

A \$75 fee may be assessed for all appointments cancelled without a 24 hour notice prior to the scheduled appointment.

Patient is responsible to understand the parameters of their insurance, and is responsible, at the time of visit, for any expenses incurred which are not covered by their plan.

Because your insurance reserves the right not to pay a claim due to their statutes of limitations, any non-aid claims will be the responsibility of the patient to pay.

By signing below, I give my consent to Beautiful Smiles of LI to administer dental treatment for myself or to my child, whether or not I am present at such visits.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Beautiful Smiles of Long Island, PLLC.

I, _____, consent to the terms stated above.

(Name of Individual Giving this Consent/ Authorization)

(Signature of Individual Giving this Consent/ Authorization)

(Date)

LASER PERIODONTICS & DENTAL IMPLANTS

Board Certified Periodontist

Dr. Adam Zatcoff
700 Hillside Avenue
New Hyde Park, NY 11040
(516)352-8492

Name: _____

DOB: _____

Zip Code: _____

Allergies: _____

Preferred Pharmacy: _____

Address: _____

Phone Number: _____