

## Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.

We look forward to working with you in maintaining your dental health.

### Patient Information

Name	_____	_____	_____	Soc. Sec. #	_____
	<i>Last Name</i>	<i>First Name</i>	<i>Initial</i>		
Address	_____				
City	_____	State	_____	Zip	_____
Cell Phone	_____	Email	_____		
Sex	<input type="checkbox"/> M <input type="checkbox"/> F	Age	_____	Birthdate	_____
				<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	
Patient Employed by	_____			Occupation	_____
Business Address	_____			Business Phone	_____
Business Email	_____				
Whom may we thank for referring you?	_____				
Notify in case of emergency	_____			Home Phone	_____
Cell Phone	_____			Business Phone	_____
Email	_____				

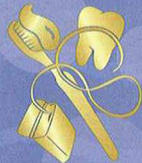
### Primary Insurance

Person Responsible for Account	_____	_____	_____	_____
	<i>Last Name</i>	<i>First Name</i>	<i>Initial</i>	
Relation to Patient	_____	Birthdate	_____	Soc. Sec. # _____
Address (if different from patient)	_____			Home Phone _____
City	_____	State	_____	Zip _____
Cell Phone	_____			Email _____
Person Responsible Employed by	_____			Occupation _____
Business Address	_____			Business Phone _____
Business Email	_____			
Insurance Company	_____			Phone _____
Insurance Email	_____			
Contract #	_____	Group #	_____	Subscriber # _____
Name of other dependents under this plan	_____			

### Additional Insurance

Is patient covered by additional insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Subscriber Name	_____	Relation to Patient	_____	Birthdate _____
Address (if different from patient)	_____			Soc. Sec. # _____
City	_____	State	_____	Zip _____
Cell Phone	_____			Home Phone _____
	_____			Email _____
Subscriber Employed by	_____			Business Phone _____
Business Email	_____			
Insurance Company	_____			Phone _____
Insurance Email	_____			
Contract #	_____	Group #	_____	Subscriber # _____
Name of other dependents under this plan	_____			

Please complete both sides.



## Dental History

What would you like us to do today? \_\_\_\_\_ Are you in dental discomfort today? \_\_\_\_\_

Former Dentist \_\_\_\_\_ Address \_\_\_\_\_

Dentist's Email \_\_\_\_\_ Phone \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last x-rays \_\_\_\_\_

Check (✓) yes or no if you have had problems with any of the following:

<input type="checkbox"/> Y <input type="checkbox"/> N Bad breath	<input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth	<input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment	<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets
<input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums	<input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth	<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold	<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting
<input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw	<input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings	<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot	<input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth

How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Y ☐ N

Other information about your dental health or previous treatment \_\_\_\_\_

## Medical History

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Email \_\_\_\_\_

Date of last visit \_\_\_\_\_ Have you had any serious illnesses or operations? ☐ Y ☐ N

If yes, describe \_\_\_\_\_

Are you currently under physician care? ☐ Y ☐ N If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion? ☐ Y ☐ N If yes, give approximate dates \_\_\_\_\_

Have you ever taken Fen-Phen/Redux? ☐ Y ☐ N

Women: Are you pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Taking birth control pills? ☐ Y ☐ N

Check (✓) yes or no whether you have had any of the following:

<input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive	<input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent	<input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Shingles
<input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis	<input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood	<input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain	<input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction	<input type="checkbox"/> Y <input type="checkbox"/> N Skin rash
<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism	<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N Liver disease	<input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves	<input type="checkbox"/> Y <input type="checkbox"/> N Fainting	<input type="checkbox"/> Y <input type="checkbox"/> N Material allergies (latex, wool, metal, chemicals)	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints	<input type="checkbox"/> Y <input type="checkbox"/> N Food allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse	<input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems	<input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles
<input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone)	<input type="checkbox"/> Y <input type="checkbox"/> N Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart surgery	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or malfunction
<input type="checkbox"/> Y <input type="checkbox"/> N Back problems	<input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care	<input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit
<input type="checkbox"/> Y <input type="checkbox"/> N Blood disease	<input type="checkbox"/> Y <input type="checkbox"/> N Heart problems	<input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss	<input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis
<input type="checkbox"/> Y <input type="checkbox"/> N Cancer	Describe _____	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis
<input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency	<input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease	<input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis
<input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever	<input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease
<input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis		
<input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments			

Is patient currently taking any medications? If yes, list all: \_\_\_\_\_

Does patient have drug allergies? If yes, list all: \_\_\_\_\_

## Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Payment is due in full at time of treatment, unless prior arrangements have been approved.**





## Flower Dental

### FINANCIAL POLICY

We would like to advise you that having insurance coverage does NOT indicate being covered at 100% for all services. Whereas some procedures may be paid in full, most of your treatments will be covered at a percentage of the charge. It is **your** responsibility to pay any co-payment amount and/or a deductible according to your insurance policy. If for any reason your insurance does not pay their portion within 60 days after your procedure, you will be responsible for that part as well.

In order to control our billing costs, we request that your portion of the charges be paid at the end of each visit unless other arrangements are made in advance. Please note that you will also be responsible for any service not covered or denied by your insurance company.

For your convenience, we will accept cash, checks and all major credit cards. Checks returned for insufficient funds will be charged a \$35.00 fee.

Because of the nature of our practice, we reserve a specific amount of time for each patient depending on the treatment. This time is extremely valuable to us. Appointments cancelled without a 24-hour notice will incur a \$50.00 broken appointment fee. Accumulation of broken appointments may lead to our refusal to accept you as a patient.

If you have an outstanding balance over 90 days, a finance charge will be applied to your account according to New York State laws, unless you have a payment plan with us. Please do not hesitate to ask us about financial arrangements that we can offer to help you pay off large balances.

-----  
Patient's Signature  
(Parent/guardian if minor)

-----  
Date



## Flower Dental

### PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Printed name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_