WELCOME TO OUR OFFICE

Steven H. Goldstein, DDS, PC

Date _____ Who may we thank for referring you? _____

Patient's Name _____ Nickname _____ Sex _____ Age ____ Date of Birth _____

Home Address _____ City _____ State ____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ E-mail _____

❑ Single ❑ Married ❑ Widowed Name of Spouse _____

Person Financially Responsible For This Account _____ Relationship _____

Billing Address _____ City _____ State ____ Zip _____

Do you have dental insurance that may cover part of this account? ❑ Yes ❑ No

Name of Carrier _____ Policy Holder _____ Date of Birth _____

Employer _____ Group # _____ SS # or ID # _____

Claims Address _____ Phone (____) _____

I hereby authorize the release of information, including the diagnosis and records of any treatment or examination rendered to my insurance company or company. The release is solely for purposes of facilitating the billing and reimbursement, directly to the dentist, of insurance benefits under which I am entitled.

_____ Signature of Patient

_____ Signature of Responsible Party

FOR ADULTS

Occupation _____

Employer _____

How Long _____

Business Phone (____) _____

FOR MINOR CHILDREN

Name of Parent or Guardian _____

Child's School _____ Grade _____

Number of Brothers and Sisters _____

Is Child Apprehensive About Dentistry? ❑ Yes ❑ No

We are a health-centered dental practice, thus we are concerned with your total well-being, not just your oral health. Please fill out the health questionnaire below completely, even if some questions may not seem relevant to your dental health. Thank you.

Do you have any complaints regarding your teeth or their related structures? ❑ Yes ❑ No If so, what? _____

Have you had any problems with a previous dental treatment? ❑ Yes ❑ No If so, what? _____

Have you seen your physician, been hospitalized, or seriously ill in the last five years? ❑ Yes ❑ No If yes, please explain below:

_____

Physicians Name & Address _____ Phone (____) _____

Reaction to Local Anesthetics? ❑ Yes ❑ No Please list _____

Please list all drugs currently being taken _____

_____

Do you use any Tobacco Products? ❑ Yes ❑ No

Allergy to any Drug or Medication? ❑ Yes ❑ No Please list _____

For Women Only: Are you now pregnant? ❑ Yes ❑ No If Yes, what month? _____

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Do you have, or have you ever had any of the following:

	YES	NO		YES	NO		YES	NO
AIDS / HIV	❑	❑	Facial Injuries	❑	❑	Latex Allergy	❑	❑
Anemia	❑	❑	Fainting	❑	❑	Lung Problems	❑	❑
Aneurysm	❑	❑	Glaucoma	❑	❑	Malignancies, Cancer	❑	❑
Arthritis	❑	❑	Hay Fever, Seasonal Allergies	❑	❑	Migraines	❑	❑
Artificial Joint	❑	❑	Head Injuries	❑	❑	Mitral Valve Prolapse	❑	❑
Asthma	❑	❑	Heart Attack	❑	❑	Nervous Disorders	❑	❑
Blackouts	❑	❑	Heart Bypass Surgery	❑	❑	Pacemaker	❑	❑
Blood Disorder	❑	❑	Heart Disease	❑	❑	Pre-Medicate for Artificial Joint	❑	❑
Blood Transfusions	❑	❑	Heart Murmur	❑	❑	Radiation Treatments	❑	❑
Chemotherapy	❑	❑	Heart Valve Replacement	❑	❑	Rheumatic Fever	❑	❑
Circulatory Problems	❑	❑	Hepatitis	❑	❑	Seizures	❑	❑
Dry Mouth	❑	❑	High Blood Pressure	❑	❑	Stroke	❑	❑
Epilepsy	❑	❑	Hypoglycemia, Diabetes	❑	❑	Tuberculosis	❑	❑
Excessive Bleeding	❑	❑	Immune Deficiencies	❑	❑	Ulcers, Digestive Problems	❑	❑
Eye Problems	❑	❑	Kidney Disease	❑	❑	Venereal Disease	❑	❑

PERSON TO CONTACT FOR EMERGENCY

Name _____ Address _____

City _____ State _____ Zip _____ Home Phone (____) _____

The information given by me on this form is correct to the best of my knowledge. I the undersigned hereby authorize the Doctor to take x-rays, study models or other diagnostic aids and give my consent to have the necessary treatment recommended for my benefit (or my minor) only after it has been mutually approved. I understand that the responsibility for payment of Dental Services in this office for myself and my dependents is mine, (regardless of insurance) due and payable at the time the services are rendered unless prior arrangements have been made. I further understand that a 1% finance charge (18% annually) will be added to my balance after 60 days.

NOTICE OF PRIVACY PRACTICE

Any patient information will not be shared with another individual or entity unless permission is given by that patient. Legal subpoenas requesting patient information are adhered to. The patient has the right to consent to or prohibit the release of his/her information. Patients have the right to inspect and obtain a copy of their PHI (Protected Health Information). Patients have the right to request restriction on disclosures of their health information. It is important to note that the provider need not grant a patient's request if a physician believes that doing so would interfere with the patient's care. However, once a patient's requested restriction is granted, the provider must adhere to the restriction. Patients have the right to request an amendment to their health information. Again the practice is not required to grant requests that are determined to be incorrect or unrelated to the provision of care. All requests and denials must be in writing. Patients have the right to receive a list of any disclosure of their PHI (Protected Health Information) this is unrelated to any treatment, payment, or the practice's health care options. We will continue to use postcards, letters and messages as a form of communication as part of your health care operations.

Date _____ Signature _____ Relation to Patient _____

FOR OFFICE USE ONLY

List Medical Changes and Medications _____

Signature _____ Date _____

List Medical Changes and Medications _____

Signature _____ Date _____

List Medical Changes and Medications _____

Signature _____ Date _____

List Medical Changes and Medications _____

Signature _____ Date _____