WELCOME TO OUR OFFICE

Steven H. Goldstein, DDS

Jason A. Curtis, DMD

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 a general dentist? ❑ Yes ❑ No Last Cleaning | X-Rays ____________

Do you have dental insurance that may cover part of this account? ❑ Yes ❑ No Employer Group or Private Policy ____________

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. The release is solely for purposes of facilitating the billing and reimbursement of insurance benefits.

____________ Signature of Patient

____________ Signature of Responsible Party

FOR ADULTS

Occupation ____________

Employer ____________

How Long ____________

Business Phone (____) ____________

FOR MINOR CHILDREN

Name of Parent or Gaurdian ____________

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 procedure? ❑ 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 require a pre-medication prior to dental procedures? ❑ Yes ❑ No

If so, please specify why & what medication ____________

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? ____________

(Continued)

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

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

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 _______________