Welcome to our office!

Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you.

Date: _____/_____/_____ Name: ____ Gender: M / F
Last *First* *Mi*

Birthdate: _____/_____/_____ SSN: ______/______/______ Occupation: _______________________________
Mo *Day* *Year*

Parent / Guardian / Caretaker Name: ____

Emergency Contact ______________________________ Relation______________ Phone:_________________

Contact Information

Address: ____
City *State* *Zip*

Cell Phone: ___________________ Home Phone: ____________________ Work Phone: ________________

Email: ____________________________________ Contact Preference: Cell Home Work Email Text

How did you hear about us? Drive/Walk by Insurance Google Facebook / Twitter / Yelp / YouTube / Instagram

Mailing Church / Temple Zocdoc TV / Radio Friend / Relative: _________________________________

Other:____

Primary Insurance Information

Who is the subscriber? Self Spouse Parent (*Please fill out subscriber information below if not 'self'*)

Insurance: __________________________ ID: ____________________________

Group Name: ________________________ Group ID: _______________________

Self Information

Employer / School: __________________________ Employer/School Phone:_________________________

Employer/School Address:____

Student Status (*dependents 19 and over*): Non-student Full-time Part-time

Subscriber Information

Subscriber Name: __________________________________ DOB: ____/____/_____ SSN: _______________
Last *First* *Mi* *Mo* *Day* *Year*

Subscriber Address (if different):____
City *State* *Zip*

Subscriber Employer: ____________________________ Employer Phone: ___________________________

Employer Address:____

Do you have a secondary Insurance Plan? Y / N Who is the subscriber? Self Spouse Parent

Insurance: __________________________ ID: ____________________________

Group Name: ________________________ Group ID: _______________________

Subscriber Name: __________________________________ DOB: ____/____/_____ SSN: _______________
Last *First* *Mi* *Mo* *Day* *Year*

Subscriber Address (if different):____
City *State* *Zip*

Subscriber Employer: ____________________________ Employer Phone: ___________________________

Employer Address:____

YONKERS AVENUE DENTAL
Complete Family and Cosmetic Care

Current Dental Health

Please check if any of the following problems apply to you:

[ ] Sensitivity
[ ] Tooth pain or discomfort when chewing
[ ] Headaches, ear aches, neck pain
[ ] Mouth ulcers or cold sores
[ ] Jaw joint pain
[ ] Broken tooth or fillings
[ ] Grinding or clenching teeth
[ ] Bleeding, swollen or irritated gums
[ ] Loose, tipped or shifted teeth
[ ] Bad breath or bad taste in your mouth

Do you or have you had any of the following?

[ ] Dentures
[ ] Partial dentures
[ ] Braces
[ ] Gum treatments
[ ] Implants
[ ] **Required to take antibiotics prior to dental treatment**

Do you smoke or use chewing tobacco? [ ] yes [ ] no
How much?__________________________For how long? ______________________________

If you could change your smile, you would:

[ ] Make my teeth whiter
[ ] Make my teeth straighter
[ ] Close spaces
[ ] Fix crowding
[ ] Replace metal fillings with tooth colored fillings
[ ] Repair chipped teeth
[ ] Replace missing teeth
[ ] Replace old crowns that don't match
[ ] Have a smile makeover

Please share the following dates:

Your last cleaning:_____/_____/_____
Your last oral cancer screening:_____/_____/_____
Your last set of complete x-rays:_____/_____/_____
Previous Dentist / Dental Office ____

What is the most important thing to you about your dental visit today?

____

What is the most important thing to you about your future smile and dental health?

____

YONKERS AVENUE DENTAL
Complete Family and Cosmetic Care

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? [ ] yes [ ] no
  Name and Number: ____
- Have you ever been hospitalized or had a major operation? [ ] yes [ ] no
  Please explain: ____
- Have you ever had a serious head or neck injury? [ ] yes [ ] no
  Please explain: ____
- Are you taking any medications, pills, or drugs? [ ] yes [ ] no
  Please List all Medications: ____
- Have you ever taken Fosamax, Boniva, Actonel, or any medications containing bisphosphonates? [ ] yes [ ] no
- Are you on a special diet? [ ] yes [ ] no **Please Explain:** ____
- Do you use controlled substances? [ ] yes [ ] no **Please list:** ____

Women: Are you

[ ] Pregnant/Trying to get pregnant? [ ] Taking oral contraceptives? [ ] Nursing?

Are you allergic to any of the following?

[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Local Anesthetics [ ]Acrylic [ ] Metal [ ] Latex [ ] Sulfa Drugs [ ] Other

If other, please explain: ____

Please check if you have, or have had, any of the following:

[ ] AIDS/HIV Positive
[ ] Alzheimer's Disease
[ ] Anaphylaxis
[ ] Anemia
[ ] Angina
[ ] Arthritis/Gout
[ ] Artificial Health Valve
[ ] Artificial Joint
[ ] Asthma
[ ] Blood Disease
[ ] Breathing Problem
[ ] Bruise Easily
[ ] Cancer
[ ] Chemotherapy
[ ] Chest Pains
[ ] Cold Sores
[ ] Congenital Heart Disorder
[ ] Convulsions

[ ] Diabetes
[ ] Drug Addiction
[ ] Dry mouth
[ ] Emphysema
[ ] Epilepsy or Seizures
[ ] Excessive Bleeding
[ ] Fainting spells/ Dizziness
[ ] Heart Attack/ Failure
[ ] Heart Murmur
[ ] Heart Pacemaker
[ ] Heart Trouble/ Disease
[ ] Hemophilia
[ ] Hepatitis A
[ ] Hepatitis B or C
[ ] Herpes
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Hives or Rash
[ ] Hypoglycemia

[ ] Irregular Heartbeat
[ ] Kidney Problems
[ ] Leukemia
[ ] Liver Disease
[ ] Low Blood Pressure
[ ] Lung Disease
[ ] Mitral Valve Prolapse
[ ] Osteoporosis
[ ] Pain in Jaw joints
[ ] Parathyroid Disease
[ ] Psychiatric Care
[ ] Radiation Treatments
[ ] Renal Dialysis
[ ] Rheumatism
[ ] Shingles
[ ] Sickle Cell Disease
[ ] Sinus Trouble
[ ] Stomach/ Intestinal Disease
[ ] Stroke

[ ] Swelling of Limbs
[ ] Thyroid Disease
[ ] Tonsillitis
[ ] Tuberculosis
[ ] Tumors or Growths
[ ] Ulcers
[ ] Venereal Disease
[ ] Yellow Jaundice
[ ] Other serious illnesses not listed above, explain:
____
____
____
____
____
____
____
____
____
____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status at every dental

Signature of Patient, Parent, or Guardian ______________________________________ **Date** ____________________

General Office Policies

Financial Policy

Our primary goal is to provide you with the best dental care. If you have dental insurance, we will strive to maximize the benefits your plan provides. If there is a balance remaining, or if you do not have insurance, we will make all remaining charges as affordable as possible. Our office uses the best materials and latest technology, and our fees are what is usual and customary for our area.

Please <u>read</u> and <u>initial</u> next to each statement below:

____ I am responsible for all charges at Yonkers Avenue Dental regardless of dental insurance benefits. Yonkers Avenue Dental will file all insurance claims on my behalf, will follow all regulations and requests from my insurance company, and will deduct all payments received from my insurance from my account, but all remaining charges are my responsibility and I will pay them in a timely manner.

____ I will be provided an estimate of charges and what my insurance plan will cover, but this is *not a guarantee* that my insurance company will pay exactly as estimated. I understand my insurance company imposes many limitations, exclusions, waiting periods, frequency limits, age restrictions, etc which affect the amount that will be paid on my behalf. As a result, what my insurance pays may be different than what was estimated by Yonkers Avenue Dental and I am responsible for the balance.

____ Insurance plans typically take 30-60 days to make payment after a claim is submitted. If your insurance has not made payment within 60 days, we ask you call your insurance to verify insurance payment is expected. If payment is not received within 60 days or your claim is denied, you will be responsible for paying the full amount at that time.

____ All insurance deductibles and copays are due <u>at the time of treatment</u>. Non-insurance patients must also make payment for services at time of treatment unless a payment plan or other arrangements have been made such as financing through Care Credit.

____ I hereby authorize payments of dental benefits directly to Yonkers Avenue Dental which otherwise would be payable to me.

____ I will be subject to a $25 fee for returned checks, and $35 monthly late fee for account balances over 90 days

We accept payment via cash, check, credit card, or Care Credit.

Late Notification / No-show Policy

We understand that situations arise in which you must reschedule your appointment, but we do request you provide at least **24 hours notice** of the cancellation. Our practice firmly believes that good doctor/patient relationship is based upon understanding and good communication.

____ I will provide at least 24 hours notification if I must reschedule an appointment. I will be subject to a **$25 cancellation fee** for weekday and a **$50 fee** for Saturday appointments per patient when I give less than 24 hours notice or simply do not show. Exceptions are rare and will be considered on a case by case basis. The fee must be paid at the following appointment before future treatment will be rendered.

____ If I simply do not show for appointments twice, without notification, I may be dismissed from the practice.

I have read and understand the Financial and Late Notification policies at Yonkers Avenue Dental.

Signature____**Date** ______________________

HIPAA Policy and Office Consents

We will use your Health Information within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental labs, pharmacies or other health care personnel providing you treatment. It also may be used:

TO OBTAIN PAYMENT

We may include your health information with an invoice used to collect payment for treatment you receive. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with the companies with similar commitment to the security of our health information.

TO CONDUCT HEALTH CARE OPERATIONS

Your health information may be used during training programs and evaluation programs. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing or credentialing activities.

IN PATIENT REMINDERS

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, letters, telephone reminders, email or texting.

PUBLIC HEALTH AND NATIONAL SECURITY

We may require to disclose to Federal Officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or a medical device.

FAMILY, FRIENDS, AND CARE GIVERS

We may share your health information with those you tell us will be helping you with home hygiene, treatment, medication, or payment. We will be sure to ask your permission first. If there is an emergency, where you are unable to tell us what you want, we will use our very best judgement when sharing your health information only when it will be important to those participating in providing your care.

COPY OF RECORDS

You are entitled to a copy of your records from our office. You may be subject to a records production fee of $0.75 per printed page, and $10 per printed page for xrays or other diagnostic images. Please allow 7-10 business days for these records to be prepared and mailed. An emailed copy option is also available.

CONSENT FOR SERVICES and PHOTOGRAPHY

During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, oral pathology, pediatric dentistry, and radiography.

No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results. Yonkers Avenue Dental will do everything possible to minimize unanticipated or unintended outcomes.

ANESTHETICS: Most procedures are performed with a local anesthetic (commonly referred to as *Novocain and Zylocaine).* In rare instances, allergic reactions may occur, so you are requested to inform our office staff of any known allergies you may have. Some sedative or pain medication may cause drowsiness. Therefore, when these medications are used, you would need to make arrangements for transportation with another person.

INFORMED CONSENT AND AURTHORIZATION: I certify that I have read and understand this Informed Consent. I understand that potential complications and problems may include, but are not limited to, those described in the treatment and discussed with me. I understand that during and following the treatment, and in the future, conditions may become apparent that warrant additional or alternative treatment pertinent to the success of comprehensive treatment. Recognizing the potential problems and risks of dental treatment, authorization is given for dental treatment to be rendered by the dentist and office staff. I also approve any modification in design, materials, or care, if it is felt this is for my best interests.

PHOTOGRAPHY: Photos and video help us better see and explain dental conditions. I authorize the doctor and/or staff to take photographs and/or videos of me or dependent for for diagnosis, to understand and improve the outcome of my case, and/or for demonstration or marketing purpose on or offline through print publication or online media. My name will be kept confidential. I do not expect compensation, financial or otherwise, for use of these photographs. ☐ Check this box if you would only like to use photos/video for diagnosis and treatment only.

*Patient/Parent/Guardian Signature*____*Date* ________________