

WELCOME TO

Advanced Dental
Your source for complete, compassionate dental care.

New Patient Name and Information:

Last Name: _____ First Name: _____
Middle Name: _____ Title: Jr. Sr. II III Mr. Ms. Mrs.
Address: _____ City: _____
State: _____ Zip: _____ E-Mail Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Sex: F M Marital Status: Single Married Divorced Widowed Other
Social Security Number: _____ - _____ - _____ Date of Birth: _____
Referred By: _____ Emergency Contact _____ Phone: _____

Person Responsible for Account (Guarantor)

Last Name: _____ First Name: _____
Middle Name: _____ Title: Jr. Sr. I II III Mr. Ms. Mrs.
Address: _____ City: _____
State: _____ Zip: _____ Home Phone: _____

Patient relation to Guarantor: *Self Spouse Child Other*

Dental Insurance? Yes No (If yes, Please complete the following information)

Primary Insurance

Insurance holder name: _____ Employer: _____
Insurance Company: _____ Insurance Plan: _____
Group Number: _____ Social Security Number: _____ Date of Birth: _____

Are You Insured by Another Company? Yes No (If yes, Please complete the following information)

Secondary Insurance

Insurance holder name: _____ Employer: _____
Insurance Company: _____ Insurance Plan: _____
Group Number: _____ Social Security Number: _____ Date of Birth: _____

Fees and Payments:

We make every effort to keep down the cost of any dental care. You can help by paying upon completion of each visit. Other arrangements can be made with our office depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms but please complete the identifying information at the top of the form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the dentist named of the insurance benefits otherwise payable to me. I understand all balances on account are my responsibility.

Signature of Responsible Party: _____

ADVANCED DENTAL & ORAL SURGERY

PATIENT CONSENT/ACKNOWLEDGEMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by Advanced Dental and Oral Surgery, our staff, and our business associated for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this Advanced Dental and Oral Surgery at (845) 569-2000 and requesting revised Notice. We will also post any revised notice in the Waiting Room.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use of disclosure of your protected health information, but this must be in writing. Under the law, we have the right to refuse to treat you should you chose to refuse to disclose your Protected Health Information (PHI).

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF **OUR NOTICE** OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THE ACKNOWLEDGMENT.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY.

Name _____ Date _____

AUTHORIZATION FORM

AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use of disclosure of my individually health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____

Persons/organizations providing the information:
Advanced Dental & Oral Surgery
401 Windsor Hwy P.O. Box 444
Vails Gate, NY 12584

Persons/Organizations receiving the information

HEALTH QUESTIONNAIRE

PATIENT NAME: _____ **D/O/B** _____ **DATE:** _____

To our patients:
Health problems that you might have or medication that you may be taking could have an important interrelationship with the care that you will be receiving.
Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Patient Dental History		yes/no	Comments			yes/no	Comments
1	Do your gums bleed while brushing or flossing?			8	Do you have frequent headaches?		
2	Are your teeth sensitive to hot or cold liquids/foods?			9	Do you clench or grind your teeth?		
3	Are your teeth sensitive to sweet or sour liquids/foods?			10	Do you bite your lips or cheeks frequently?		
4	Do you feel pain to any of your teeth?			11	Have you ever had any difficult extractions?		
5	Do you have any sores or lumps in or near your mouth?			12	Have you had any orthodontic work?		
6	Have you had any head, neck or jaw injuries?			13	Have you ever had prolonged bleeding following extractions?		
7	Have you ever experienced any of the following problems in your jaw?			14	Have you ever had instruction on correct method to brushing your teeth?		
	A) Clicking?						
	B) Pain (joint, ear, side of face)?						
	C) Difficulty in opening or closing?						
	D) Difficulty in Chewing?			15	Have you ever had instructions on the care of your gums?		
16	What would you like to change about your smile? _____						

Health History

Have you had or currently have/use...	Yes/No	Comments	Have you had or currently have/use...	Yes/No	Comments
1 Rheumatic Fever?			21 Abnormal bleeding?		
2 Damaged Heart valves/ mitral valve prolapse?			22 Jaundice, hepatitis or liver disease?		
3 Heart murmur?			23 Infectious mononucleosis?		
4 High blood pressure?			24 Gallbladder trouble?		
5 Low blood pressure?			25 Fainting spells?		
6 Chest pain, angina?			26 Convulsions, epilepsy?		
7 Heart attack(s)?			27 Stroke?		
8 Irregular Heart beat?			28 Thyroid trouble?		
9 Cardiac pacemaker?			29 Diabetes?		
10 Heart surgery?			30 Low blood sugar?		
11 Bronchitis, chronic cough?			31 Kidney trouble?		
12 Asthma?			32 Are you on dialysis?		
13 Hayfever/Sinus problems?			33 Swollen ankles, arthritis or joint disease?		
14 Tuberculosis?			34 Stomach ulcers?		
15 Emphysema?			35 Contagious diseases?		
16 Difficulty breathing?			36 Sexually transmitted diseases?		
17 Any other lung trouble?			37 AIDS or HIV infection?		
18 Do you smoke?			38 Problems of the immune system?		
19 Blood disorder such as anemia?			39 A tumor or growth?		
20 Bruise easily?			40 Mental health problems?		

<i>Have you had or currently have/use...</i>	<i>Yes/No</i>	<i>Comments</i>	<i>Have you had or currently have/use...</i>	<i>Yes/No</i>	<i>Comments</i>
41 Removable dental appliances?			46 Eye disease/Glaucoma?		
42 Are you on a diet?			47 X-ray treatment/Chemotherapy?		
43 Drugs?			48 Blood transfusion?		
44 Alcohol Beverages?			49 Pain and clicking of jaws when eating?		
45 Contact lenses?			50 Malignant Hyperthermia?		
51 Fen-Phen (diet pills)?					

Medications

	<i>Yes</i>	<i>No</i>	<i>Comments</i>
Are you now taking any kind of medicine, drug or pills for any purpose?			
Anticoagulants?			
Tranquilizers?			
Cortisone?			
Other medications? (please list them) _____			

Allergies

Are you allergic to or had a reaction to:	<i>Yes</i>	<i>No</i>	<i>Comments</i>
Local anesthetics?			
Penicillin or other antibiotics?			
Sulfa Drugs?			
Barbiturates, sedatives or sleeping pills?			
Aspirin?			
Iodine?			
Codeine or other narcotics?			
Other medications?			
Allergies other than drug allergies? (please list them) _____			

Is there any condition concerning your health of family's anesthetic history that the doctor should be told?
 Yes No

Women:

	<i>Yes</i>	<i>No</i>	<i>Comments</i>
Is there a possibility that you may be pregnant?			
Estimated delivery date?		/ /	
Are you nursing?			
Are You taking birth control pills?			

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist or any member of his staff, responsible for any errors or omissions that I may have made in the completions of this form.

Signature of Doctor: _____ **Signature of Patient:** _____