NationalDental

Patient Dental Intake Form

Patient Information

Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Email: _____

Sex: ❑ M ❑ F Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Partnership ❑ Widowed

Employer or School: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse, partner or parent name: _____

Person to contact in case of an emergency: _____ Phone: _____

How did you learn about our practice or whom may we thank for referring you? _____

Who is responsible for your account and payment? (if different from previous listing): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ Birthdate: _____

Dental Insurance

Insurance company: _____ Phone #: _____

Subscriber's Social Security # _____ Group # _____ ID #: _____

Who's the policy holder? _____ Policy holder Date of Birth: _____

Employer offering this insurance? _____ Phone: _____

Do you have any additional insurance? (*if applicable, please complete the following*)

Insurance company: _____ Phone # _____

Subscriber's Social Security # _____ Group # _____ ID # _____

Who's the policy holder? _____ Policy holder Date of Birth: _____

Employer offering this insurance? _____ Phone: _____

Dental History

Reason for today's visit: _____

Date of last dental care visit: _____ Date of last dental x-rays: _____

Why did you leave your previous dentist? _____

Check if you have any problem with the following:

❑ Bad breath
❑ Bleeding gums
❑ Clicking or popping jaw
❑ Food collection between certain teeth
❑ Grinding teeth
❑ Loose teeth or broken fillings
❑ Periodontal treatment
❑ Sensitivity to any of the following: cold, hot, sweets
❑ Sensitivity when biting
❑ Sores or growth in your mouth

How often do you floss? _____ How often do you brush? _____

Tell us a little about your teeth? _____

Do you like your smile? _____

Medical History

Your physician:_____ Date of last visit: _____

Have you ever taken Fen-Phen/Redux? ❑ Yes ❑ No

Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? ❑ Yes ❑ No

Have you had any serious illnesses or operations? ❑ Yes ❑ No

If yes, describe: _____

Have you ever had a blood transfusion? ❑ Yes ❑ No

If yes, give approximate dates: _____

Do you snore? ❑ Yes ❑ No

Have you had a sleep study? ❑ Yes ❑ No

Women: are you pregnant? ❑ Yes ❑ No

Are you nursing? ❑ Yes ❑ No

Are you taking birth control? ❑ Yes ❑ No

Check if you have or have had any of the following:

- ❑ Anemia
- ❑ Arthritis, rheumatism
- ❑ Artificial heart valves
- ❑ Artificial joints, pins, etc.
- ❑ Asthma
- ❑ Bleeding abnormally
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Congenital heart lesions
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart murmur
- ❑ Heart problems
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ HIV or AIDS
- ❑ Jaw pain
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Mitral valve prolapse
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Radiation treatment
- ❑ Respiratory disease
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Sexually transmitted disease
- ❑ Stroke
- ❑ Swelling of feet or ankles
- ❑ Thyroid problems
- ❑ Tobacco use
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer

List medications (including non-prescription medication) you are currently taking and the correlating diagnosis:

Medication	Diagnosis

Please list any allergies you may have:

Allergy	Allergy

To the best of my knowledge, the above information is complete and correct.
I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health.

_____ _____

Patient or Guardian Signature *Date*

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect __/__/__ and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our practices or for additional copies of this notice please contact us using this information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment payment and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to a physician or other health care provider providing treatment to you.

PAYMENTS: We may use and disclose your health information to obtain payment for services we provide to you.

HEALTH CARE OPERATIONS: We may use and disclose you health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities. Reviewing the competence or qualifications of health care professionals, evaluating practitioners and provider performance conducting training programs accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment payment or health care operations you may give us written authorization to use you health information or to disclose it to anyone for any purpose if you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while in effect. Unless you give us a written authorization we cannot use or disclose you health information for any reason except those described in this notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you as described in this patient rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify or assist in the notification of including identifying or locating a family member your personal representative or another person responsible for you care of you location you general condition or death. If you are present then prior to use or disclosure of your health information we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practices to make reason able inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x- rays or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIERED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to you health or safety or the health or safety of others.

560 S. Broadway
Hicksville NY, 11801
516-535-0544

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You may refuse to sign this acknowledgement ****

I, (full name) _____, did receive a copy of

this office's Notice of Privacy Practices on (today's date) _____.

BELOW LINE FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

( ) Individual refused to sign
( ) Communications barriers prohibited obtaining the acknowledgement
( ) An emergency situation prevented us from obtaining
( ) Other (please specify)

_____

_____

_____

NationalDental

560 S. Broadway
Hicksville, NY 11801

Patient Full Name: _____

Date: _____

Financial Policy

Please read the terms of our financial policy below. Your signature below indicates you understand and agree with this policy.

1. Payment for services is due at the time services are rendered unless prior arrangements have been made. Any payment owed will be collected prior to being seen by your provider.

2. We accept the following forms of payment: Cash, Check, Credit Cards (Visa, MasterCard, Discover and American Express) and Debit Cards.

    a. Checks that are returned to our office from your financial institution are subject to a $25.00 returned check fee. This fee covers the processing fees that are charged to our office.

3. In addition, we offer CareCredit & Lending Club, both patient payment programs, providing a full range of No Interest and Extended Payment Plans for all patients and treatments.

4. No refunds will be issued once treatment plan has been approved and commenced.

5. We accept most dental insurances:

    b. Please note that having active insurance coverage does not mean a guarantee of payment in full. Payment will be determined at the time the claim is processed by your insurance carrier.
    c. YOU ARE RESPONSIBLE for any amount not covered by your dental plan, such as, deductibles, co-payments and additional services. These are due at the time of treatment.

6. National Dental also offers the NATIONAL DENTAL MEMBERSHIP PLAN designed for your specific needs. Be sure to ask a National Dental team member how you and your family can benefit from this program.

_____ _____

Signature of Patient or Responsible Party National Dental Representative

NationalDental

GENERAL CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist(s) of National Dental PLLC. to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs, or diagnostic aids:
   - Consult with examination for future treatment.
   - Preventive hygiene treatment (prophylaxis), and the application of topical fluoride.
   - Application of plastic "sealants" to the grooves of the teeth.
   - Treatment of diseased or injured teeth with dental restorations (fillings, crowns, and onlays).
   - Treatment of diseased or injured teeth with endodontic (root canal) therapy if needed.
     **Breakage of dental instruments inside tooth canals requiring additional treatment.
   - Replacement of missing teeth with dental prostheses (i.e. implants, bridges, partials, and full dentures).
   - Removal (extraction) of one or more teeth.
     **Involvement of the nerves during oral surgery or administration of local anesthesia resulting in temporary or possible permanent numbness or tingling of the lip, chin, tongue, or other areas of the face or neck.
     **Sinus involvement during the removal of upper molars, which may require additional treatment or surgical repair at a later date or by an oral surgeon.
     **Incomplete removal of tooth fragments to avoid injury to vital structures such as nerves or sinus, occasionally small root tips may be left in place.
     **Jaw fracture- While quite rare, it is possible in difficult or deeply impacted teeth.
   - Treatment of diseased or injured oral tissue (hard and/or soft).
   - Use of sedative drugs to control apprehension and/or disruptive behavior.
   - Treatment of malposed (crooked) teeth and/or oral development of growth abnormalities.
2. I understand that there are risks involved in this treatment, and hereby acknowledge that these risks will be explained to me. I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I will be advised that the success of the dental treatment to be provided will require that the patient and/or parents of the patient to follow post-care instructions of the dentist. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his auxiliaries must be maintained.
4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I, therefore, authorize and request the performances of any additional procedures that are deemed necessary for desirable oral health and well being, in the professional judgment of the dentist.
5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip or cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
6. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indention or ring around the nose, which disappears shortly after procedure. I understand and have been informed of the above risks and complications.
7. I also authorize the doctor to use anonymized photographs, radiographs, other diagnostic materials, and treatment records for the purpose of teaching, research, and scientific publications.
8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided an answer to the questions which may arise during and after the course of my treatment.
9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

(x)_____ (x)_____

Print Patient's Name **Print Name of Parent or Guardian (if applicable)**

(x)_____ (x)_____

Signature of Patient or Parent/Guardian **Date** **Witness Signature** **Date**