Central Park Dentistry
30 Central Park South
Suites 2B & 2C
New York, NY 10019

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Sex: ☐ M ☐ F Family Status: ☐ Single/Child ☐ Married ☐ Other: _____ Birth Date: _____

Email: _____ Social Security Number: _____

Phone (Home): _____ (Work): _____ *(Mobile):* _____

Address: _____
Street Apt/Suite/Floor City State Zip

Health History Information

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis – A, B, or C
☐ High Blood Pressure
☐ Hay Fever
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders - Depression
☐ Migraines
☐ Nervous Disorders - Anxiety
☐ Pacemaker
☐ Pregnancy
Due date: _____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Skin Disorders
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
☐ _____

Please list any medications you are currently taking: _____

☐ No ☐ Yes Do you smoke? If yes, how many times per week: _____
☐ No ☐ Yes Do your gums ever bleed? If yes, explain: _____
☐ No ☐ Yes Do you have any loose teeth? If yes, where: _____
☐ No ☐ Yes Does food catch between your teeth? If yes, where: _____
☐ No ☐ Yes Do you have a specific dental concern? If yes, explain: _____
☐ No ☐ Yes Are your teeth sensitive to heat, cold, or anything else? If yes, explain: _____
☐ No ☐ Yes Have you had any complications following dental treatment? If yes, explain: _____
☐ No ☐ Yes Are you currently in pain? If yes, where, and describe sensation: _____
☐ No ☐ Yes Have you been admitted to a hospital or needed emergency care during the past two years?
If yes, please explain: _____
☐ No ☐ Yes Are you now under the care of a physician? If yes, explain: _____
Name of Physician: _____ Phone: _____
☐ No ☐ Yes Do you require antibiotics before dental treatment?
☐ No ☐ Yes **Are you happy with the way your smile looks?** If no, why: _____

Emergency Contact: _____ **Relationship to Patient:** _____ **Phone:** _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

How did you hear about our practice? ☐ Another Patient: _____ ☐ Other: _____

Employment Information

Employer Name: _____ Occupation: _____

Address: _____

Street Apt/Suite/Floor City, State Zip Code Phone

Dental Insurance Information

Primary

Name of Policy Holder: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Last First

Policy Holder's Birth Date: _____ ID #: _____ Group #: _____

Dental Insurance Provider / Plan Name: _____

Secondary

Name of Policy Holder: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Last First

Policy Holder's Birth Date: _____ ID #: _____ Group #: _____

Dental Insurance Provider / Plan Name: _____

Medical Insurance Information

Primary

Name of Policy Holder: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Last First

Policy Holder's Birth Date: _____ ID #: _____ Group #: _____

Secondary

Name of Policy Holder: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Last First

Policy Holder's Birth Date: _____ ID #: _____ Group #: _____

Pharmacy Information

Name of Pharmacy: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

Street City State Zip Code

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

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www.cpsdent.com

Practice Policies

Cancellation/ No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "FULL" appointment book.

* **If an appointment is not cancelled at least 24 hours in advance you will be charged a $75 fee; this is not covered by your insurance company.**

Cancellation/ No Show Policy for Long Appointments

Due to the large block of time needed for surgical procedures, last minute cancellations can cause problems and added expenses for the office.

* **If surgery is not cancelled at least 48 hours in advance you will be charged a $150 fee; this is not covered by your insurance company.**

Reserving appointments

For procedure appointments longer than 1.5 hours, we ask for a reservation fee to hold the spot.

Scheduled Appointments

We understand that delays can happen, however, we must try to keep all patients and doctors on time.

* **Please contact our office by phone, email or text if you anticipate being more than 20 minutes late, we may be able to accommodate you with another time slot, if not we will need to reschedule.**

Account Balances

We will require that patients with self-pay or insurance balances do pay their account balances to $0 prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may speak to an office representative with whom they can review their account and concerns. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____ _____ ___/___/____

Print Name **Patient or Guardian Signature** **Date**

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Patient HIPAA Consent Form

I understand that I have certain rights regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) this provides a safeguard to my privacy.

To the best of my knowledge, the information given on the Welcome Forms is complete and correct. I understand that it's my responsibility to inform my doctor if I, or my minor child ever have a change in health.

I certify that I, and/or my dependent(s) have insurance coverage with the insurance company(ies) listed on the Welcome Forms and assign directly to the Doctor also listed on the Welcome forms all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charged whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The Dentist (Doctor) listed on my Welcome Forms may use my health care information and may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payment services and determining insurance benefits payable for services.

I understand that Dentistry, like other medical services are not an exact science and that, therefore, reputable practitioners cannot guarantee results. However, the Doctors do guarantee that they will use all of their experience, skills and technology to provide me with the best dental care. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

PRINT Name of Patient: Date

_____ _____

SIGNATURE of Patient (or Guardian) Date

_____ _____