WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No	Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Chew on one side of mouth	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
			Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
			Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
			Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
			Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
			Foreign objects	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
			Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
			Gums swollen or tender	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No
			Jaw pain or tiredness	☐ Yes	☐ No	How often do you floss? _____		
			Lip or cheek biting	☐ Yes	☐ No			
			Loose teeth or broken fillings	☐ Yes	☐ No	How often do you brush? _____		

HEALTH HISTORY

Physician's Name _____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
		High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No		
Cortisone Treatments	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

BAY SHORE FAMILY DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of
Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____

_____

_____

BAY SHORE FAMILY DENTAL

INFORMED CONSENT FORM FOR DENTAL TREATMENT.

FILLINGS:

BENEFITS:
Eliminate decay.
Relieve pain.
Fill in a hole or a space in a tooth.
Cover eroded areas.
Protect a sensitive tooth.
POSSIBLE COMPLICATIONS:
Tooth may abscess from felling, may fracture tooth, tooth may be sensitive to temperature change; toxicity from silver filling is alleged by some, filling may fall out.
CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
May loose tooth.
Tooth may fracture.
Decay will get larger.
Pain will get worse.
May result in need a root canal.
ALTERNATIVES:
Temporary filling, extraction

EXTRACTIONS:

BENEFITS:
Last resort for non-salvageable tooth.
Eliminate pain
Remove teeth that are out of position.
Eliminate infections.
POSSIBLE COMPLICATIONS:
Fractured particles may remain, irritation to nerves may cause temporary or permanent numbness, part or all of the tooth may be lodged in sinus, requiring more surgery, bed infections may take a long time to clear up, jaw may be stiff and difficult to open for a long time, if jaw bone is very weak, it may fracture.
CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
Spread of infection.
Swelling.
Pain.
ALTERNATIVES:
None.

X-RAYS

BENEFITS:
More complete diagnosis.
Can find hidden problems.
can make a determination of treatment.
X-Rays taken by qualified personnel.
POSSIBLE COMPLICATIONS:
Exposure to X-Ray radiation (minimal), X-ray pictures remain the property of FAMILY DENTAL OFFICE.
CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
Can not perform dental services.
ALTERNATIVES:
None.

CLEANING-SCALING

BENEFITS:
Look nicer.
Clean mouth.
Eliminate odors.
Prevents gum disease.
Some portions may be performed by auxiliary personnel.
POSSIBLE COMPLICATIONS:
Sensitive teeth, feeling of space between teeth, filling may be loosened. (Normal if the filling is about to fall out). Sensitive gums.
CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
Stains on teeth.
Odors.
Gum disease.
Will lose teeth sooner.
ALTERNATIVES:
None.

BONDED FACINGS

BENEFITS:
Aesthetics - they look nicer.
Cover crooked teeth.
Close spaces and gaps.
Cover discolored teeth.
POSSIBLE COMPLICATIONS:
Edges can stain after a time and need to be freshened up (additional fee).
Breakage may occur, resulting in need for a remake, difficult to remove.
CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
None (other than appearance).
ALTERNATIVES:
Crowns

LOCAL ANESTHETICS

BENEFITS:
Avoid pain, during treatment and procedures.
POSSIBLE COMPLICATIONS:
Prolonged numbness may extend beyond normal, nerve damage, bruising (hernatoma), in rare instances, possible can sequences may include all those applicable to General Anesthesia, including allergic reactions up to end including death, (separate detail information sheet is available upon request).
CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
Mild to severe pain during and after treatment.
ALTERNATIVES:
Willingness to accept pain during and after treatment.

CROWNS-CAPS

BENEFITS:
Make you look nicer (cosmetic).
To repair a tooth that is badly broken down.
To restore a tooth that has been broken.
To eliminate a space where food is being trapped.
To hold a false tooth in place as part of a bridge.
To make a solid structure to attach a partial denture.
To splint loose teeth together to strengthen them.
the tooth no longer can be filled.
POSSIBLE COMPLICATIONS:
Porcelain portion of the crown may fracture, crown may come off and need to be re-cemented, tooth may abscess and require further treatment (may not show up until later), future decay may require a filling or a new crown.
CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
Tooth will probably fracture.
Tooth may need to be extracted.
May need a root canal in addition to the crown.
Nay need bridge work or dentures.
ALTERNATIVES:
Extraction, temporary crown, steel crown.

BRIDGE WORK:

BENEFITS:
Make you look nicer.
To replace missing teeth.
Missing teeth are not removable.
Some of the same advantages as crowns.
Can improve chewing efficiency.
POSSIBLE COMPLICATIONS:
Same as crowns.
CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
Teeth will drift and lean over.

BAY SHORE FAMILY DENTAL

INFORMED CONSENT FORM FOR DENTAL TREATMENT.

May lose back teeth due to shifting.
Periodontal problems (gum disease).
Can reduce chewing efficiency.
ALTERNATIVES:
Partial, temporary partial, no teeth in spaces.

PARTIAL (remove bridge work):

BENEFITS:
Cost.
POSSIBLE COMPLICATIONS:
Can wear on teeth.
Can rock or stress teeth - may loosen natural teeth.
Metal clasps are sometimes visible.
Decay can occur under clasps.
Usually some movement from the partial.
CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
Same as bridge work.
ALTERNATIVES:
Bridge work, temporary partial, keep spaces without teeth replacement.

ROOT CANAL

BENEFITS:
Eliminate infection.
Relieve pain.
Save tooth.

Gum disease.
Will lose teeth sooner.

POSSIBLE COMPLICATIONS:
Undiagnosable root fracture means failure and extraction.
Undiagnosable auxiliary canal means failure and extraction.
CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
Extraction of tooth.
ALTERNATIVES:
Extraction.
Bridge work.

GUM SURGERY (GINGIVECOMY

BENEFITS:
Eliminate infection.
Reduce food pockets around teeth.
Eliminate foul odors.
Reduce overgrown tissue.
Can eliminate tartar effectively.
POSSIBLE COMPLICATIONS:
May be repeated after a time, same after pain, might lose teeth if they do not respond to treatment.
CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
Will lose teeth sooner.
May not get rid of infection.
ALTERNATIVES:
More frequent appointments for scaling.

NAME OF PATIENT (please print): _____
NAME OF GUARDIAN (please print): _____

I (WE) HAVE READ THE ABOVE STATEMENTS AND RECEIVED A COPY OF THEM, AND RECOGNIZE THEIR IMPORTANCE IN HELPING ME (US) MAKE MY (OUR) DECISIONS. I (WE) ALSO UNDERSTAND THAT WHERE DECAY HAS OCCURRED, OR A TOOTH HAS FRACTURED, OR ABSCESSED THESE SAME FORCES ARE STILL WORKING ON THE TOOTH EVEN AFTER IT HAS BEEN RESTORED; THEREFORE, DECAY OR FRACTURE CAN STILL OCCUR AS THE RESTORED TOOTH IS NO BETTER THAN WHAT NATURE HAS GIVEN ME IN THE FIRST PLACE.

IN ATTENDING DENTIST AND MYSELF (OURSELVES), I (WE) SHALL FIRST PRESENT SUCH DIFFERENCE OR DISAGREEMENT TO MY ATTENDING DENTIST IN ORDER TO RESOLVE THE PROBLEM. IF WE ARE UNABLE TO AGREE ON A SOLUTION, THEN I (WE) AGREE TO TAKE THE PROBLEM TO A RECONCILIATION BOARD, SUCH AS THE DENTAL SOCIETY OR The New York State Consumer Affairs Board of Examiners AND AGREE TO ACCEPT THEIR RESOLUTION IN LIED OF PURSUING REMEDIES BY WAY OF LITIGATION.

IN CONSIDERATION OF HELPING TO KEEP COSTS OF TREATMENT AS LOW AS POSSIBLE, I (WE) ALSO UNDERSTAND THAT THE AGREEMENT IS BINDING ON MY HEIRS AND ALL OTHER FAMILY MEMBERS.

SIGNATURE: _____ DATE:____/____/____
GUARDIAN SIGNATURE: _____ DATE:____/____/____

Do you have an advance Directive? ___Yes ___No
If yes, can we have a copy for our chart? ___Yes ___No
If no, would you like to create one at this time? ___Yes ___No

X _____ _____
Signature Date:

Patient / Account Agreement

I have dental insurance coverage with _____, and I assign all benefit to Bay Shore Family Dental, if any otherwise payable to me for all services rendered. I understand that I am financially responsible for all charges incurred whether or not paid by my insurance company, including deductibles and co-payments. Interest of 1 ½ percent per month {18% annually} may be charged to overdue accounts. A fee of $30.00 per ½ hour is charged for broken appointments without 24-hour notice I hereby authorize the release of all information necessary to secure payment of benefits. Any collection costs {including attorney's fee} will be charged to delinquent accounts, and may be reported to credit rating agencies. *I realize that insurance assignment is a courtesy extended by Bay Shore Family Dental and that I am ultimately responsible for payment of all services rendered if the insurance company denies payment for any reason to this office.*

Account Holder's Signature: _____

Print: _____

Date: _____