MONROE DENTAL ARTS LLC

91 Lakes Road

Monroe, NY 10950

Tel- (845)782-8606

Patient Registration

Date:___________________________

Patient Name:____ DOB:__________________________

PATIENT DETAILS

Address:____

City, State, Zip:____ Marital Status: ___________________________

Gender ☐ Male ☐ Female Social Security #:____

CONTACT INFORMATION

*Email:____ (Work #)______________________________Ext:_______

(Home #)____ *(Cell#)____

Driver License Number:____ Driver License Issuing State: __________

EMPLOYMENT INFORMATION

Employer Name:____ Phone #:____

Address:____

City, State, Zip:____

RESPONSIBLE PARTY'S INFORMATION

Relationship to Patient:_________________________________ Home #:____

Name:____ Cell #:____

Address:____City, State, Zip:_______________________________________

DOB:_______________________ Social Security #:____

PRIMARY INSURANCE

Relationship to Patient: _________________________ Insurance Company:____

Named of Insured:____ DOB of Insured:________________________

ID Number:____ Group Number:_____________________

Insurance Company Address:____

SECONDARY INSURANCE

Relationship to Patient: _________________________ Insurance Company:____

Named of Insured:____ DOB of Insured:________________________

ID Number:____ Group Number:_____________________

Insurance Company Address:____

PATIENT DETAILS

Last Dental Visit:____________________ Reason for Visit:____

Have you ever had complications ☐ Yes ☐ No If yes, explain____

Following dental treatment ☐ Yes ☐ No

Have you ever been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

Are you now under care of a physician? ☐ Yes ☐ No If yes, explain____

Physician Name:_______________________________________ Physician Phone#:__________________________________

DENTAL HISTORY

Former Dentist: ____

Date of Last X-Rays:______________________________ Date of Last Dental visit:________________________________

Reason for Today's visit?:____

How often do you brush?:____________________________ How often do you floss?:_________________________________

Select Yes or No if you had any of the following:

Bad Breath	☐ Yes ☐ No	Dry mouth	☐ Yes ☐ No
Bleeding Gums	☐ Yes ☐ No	Food collection between teeth	☐ Yes ☐ No
Blisters on lips or mouth	☐ Yes ☐ No	Grinding teeth	☐ Yes ☐ No
Burning sensation on tongue	☐ Yes ☐ No	Jaw pain or tiredness	☐ Yes ☐ No
Fingernail biting	☐ Yes ☐ No	Loose teeth or broken fillings	☐ Yes ☐ No
Foreign objects	☐ Yes ☐ No	Mouth pain, brushing	☐ Yes ☐ No
Gums swollen or tender	☐ Yes ☐ No	Pains around ear	☐ Yes ☐ No
Lip or cheek biting	☐ Yes ☐ No	Sensitivity to cold	☐ Yes ☐ No
Mouth breathing	☐ Yes ☐ No	Sensitivity to sweets	☐ Yes ☐ No
Orthodontic treatment	☐ Yes ☐ No	Sores or growths in mouth	☐ Yes ☐ No
Periodontal treatment	☐ Yes ☐ No		
Sensitivity to heat	☐ Yes ☐ No		
Sensitivity when biting	☐ Yes ☐ No		
Chew on side of mouth	☐ Yes ☐ No		
Cigarette, pipe, or cigar smoking	☐ Yes ☐ No		
Clicking or popping jaw	☐ Yes ☐ No		

MEDICAL HISTORY

Have you ever had any of the following please select yes to those that apply

AIDS ☐ Yes ☐ No

Anemia ☐ Yes ☐ No

Artificial joints ☐ Yes ☐ No

Blood disease ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

Epilepsy ☐ Yes ☐ No

Fainting ☐ Yes ☐ No

Growths ☐ Yes ☐ No

Head injuries ☐ Yes ☐ No

Heart murmur ☐ Yes ☐ No

High blood pressure ☐ Yes ☐ No

Kidney disease ☐ Yes ☐ No

Mental disorders ☐ Yes ☐ No

Pacemaker ☐ Yes ☐ No

Radiation treatment ☐ Yes ☐ No

Rheumatic fever ☐ Yes ☐ No

Sinus problems ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

Tumors ☐ Yes ☐ No

Venereal disease ☐ Yes ☐ No

Allergies ☐ Yes ☐ No

If yes, please specify:________________

____

Arthritis ☐ Yes ☐ No

Asthma ☐ Yes ☐ No

Cancer ☐ Yes ☐ No

Dizziness ☐ Yes ☐ No

Excessive bleeding ☐ Yes ☐ No

Glaucoma ☐ Yes ☐ No

Hay fever ☐ Yes ☐ No

Heart disease ☐ Yes ☐ No

Hepatitis ☐ Yes ☐ No

Jaundice ☐ Yes ☐ No

Liver disease ☐ Yes ☐ No

Nervous disorders ☐ Yes ☐ No

Pregnancy ☐ Yes ☐ No

If yes, DUE DATE:__________________________

Respiratory problems ☐ Yes ☐ No

Rheumatism ☐ Yes ☐ No

Stomach problems ☐ Yes ☐ No

Tuberculosis ☐ Yes ☐ No

Ulcers ☐ Yes ☐ No

Other ☐ Yes ☐ No

If yes, explain_______________________________

____

ALLERGIES

Codeine allergy ☐ Yes ☐ No

Penicillin allergy ☐ Yes ☐ No

Other allergies ☐ Yes ☐ No

____

____

Please list any and all medication:______________________

____

____

AUTHORIZATION

To the best of my knowledge, all of the proceeding 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.

____ _______________________________

Patient Signature Date

CONSENT FOR SERVICES

Thank you for choosing MONROE DENTAL ARTS LLC., we pledge to provide you with the highest quality of dental care. After all, it's the loyalty and continued support of patients like you who have helped MONROE DENTAL ARTS succeed in our community. We appreciate you being prompt and we recognize the value of your time. However, we do reserve the right to apply a minimum fee of $75.00 to your account if you fail to keep your appointment (without 24 business hour notice). 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 cash at the time services are performed.

Patients who carry dental insurance understand that all dental services 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 patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services in the assumption that our charges will be paid by an insurance company.

A service charge of 2.5% per month (30% per annum) on the unpaid balance will be charges on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. If your account goes to the collections agency, then you have to pay the balance and attorney fees. I understand that the fee estimated list 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 are 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 billed unless objected to, by me, in writing, within the time for payment thereof.

I further agree that a waiver of any breach of anytime 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.

____ _______________________________

Signature of patient, parent or guardian Date

____ _______________________________

Signature of guarantor of payment/responsible pay Date

Please read, check off and sign the following

☐ I authorize the release of all necessary information to any insurance company(s), claim administrator, and consulting health care professionals, information concerning healthcare, advice or supplies provided.

☐ I authorize payment of benefits directly to my provider.

☐ I understand that all co-payments are due at the time treatment is provided.

☐ I have read this form and agree to be financially responsible to all fees regardless of insurance coverage.

____ _______________________________

Signature of patient, parent or guardian Date

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and how you may obtain access to this information.

The office has always recognized the importance of privacy; this new federal law formalizes practices that have been followed routinely.

Background; In 1996 Congress recognized the need for national patient privacy standards and, as part of the Health Insurance Portability and Accountability Act, as abbreviated HIPPA, ordered that a set of rules be established to control how health information is used, disclosed, and maintained by doctors, hospitals, and health plans. Health Information is considered sensitive and personal and the law establishes consumer protection and limits the sharing of such information as do similar protections already enacted for bank accounts, credit cards and even video rentals,

* By, law, consent is not required to discuss your medical treatment with your other doctors or healthcare providers. This allows, also, for a prescription to be called into your pharmacy and for scheduling of surgery in a hospital.

* Additionally, none is needed in the course of carrying out health care operations, such as assessment, or in communications with your insurance carrier for payment related issues, or for incidental uses, such as announcing a name in a waiting room or the use of a sign-in sheet.

* However, this office has always gone one step further in protecting you and does not believe in releasing specific information about you to any business or government entity without your written consent.

* Specific authorization is required to disclose protected information in a non-routine circumstance, such as your employer for use in marketing a product for you.

* Medical information about you may be related to research and public health uses, as long as you believe it to be incomplete or inaccurate,

* You have the right to review when and to whom your information was related.

*Portions of this notice may be modified, as long as you are notified.

*Should you believe that your privacy rights have been compromised, you report the violation, without penalty to you, to this office or the Secretary of Health.

* The law requires that you acknowledge receipt of this notice, this has been included on the signature release of your registration forms.

________________________________ ________________________

Patient Signature Date

MONROE DENTAL ARTS POLICIES

* If your appointment should not be cancelled 24 business hours in advance, we receive the right to charge a cancellation fee of $75.00 per appointment. (Emergencies are taken into consideration)
* MONROE DENTAL ARTS will need to complete a series of x-rays and a comprehensive oral evaluation of their own in order to diagnose a proper treatment,
* If coming in for an emergency, periapical x-rays are taken. For recall patients, a full series is taken once every 3-5 years upon insurance history.

Thank You for your consideration

MONROE DENTAL ARTS

________________________________ ________________________

Patient Signature Date