PERIO nyc

Aesthetic Periodontal and Implant Therapy

Today's Date_____

PATIENT DEMOGRAPHIC INFORMATION

Mr. Ms. Mrs. Dr._____

Last Name, First Name, Middle Initial

Address_____ Apt. No._____

City, State, Zip_____

Home Phone (_____)_____Work Phone (_____)_____Ext._____Cell Phone (_____)_____

Email Address_____I prefer to be contacted via: Home Work Cell Email

Name of Emergency Contact_____ Contact # (_____)_____

Birthdate_____ Social Security # (if needed for insurance)_____-_____-_____

Referred By_____General Dentist_____Phone (_____)_____

INSURANCE INFORMATION

DENTAL INSURANCE

Insurance Co._____

Name of Insured_____

Policy ID# _____

Relationship to Patient_____

Insured's Birthdate_____

Group Name_____Group #_____

Claims Address_____

Insurance Phone # (_____)_____

MEDICAL INSURANCE

Insurance Co._____

Name of Insured_____

Policy ID#_____

Relationship to Patient_____

Insured's Birthdate_____

Group Name_____Group #_____

Claims Address_____

Insurance Phone # (_____)_____

_____ I am not covered by any Dental Insurance at this time

EDWARD GOTTESMAN, DDS*, TARA BOGART, DDS & ANAMARIA CASTILLO, DMD, MS*

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PHARMACY INFORMATION

Pharmacy Name_____

Address of Pharmacy_____

City, State, Zip_____

Pharmacy Phone #_____

Special Instructions (example: delivery, allergies)_____

_____

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HEALTH QUESTIONNAIRE

Your Name_____Your Age_____
Last Name, First Name, Middle Initial

Physician's Name_____Physician's Phone (_____)_____

Month/Year of Your Last Medical Examination_____

How would you describe your present health (Circle One) EXCELLENT GOOD FAIR POOR UNSURE

YES NO

☐ ☐ Has there been any change in your general health in the past year?_____

_____

☐ ☐ Have you had a serious illness, operation or hospitalization during the past five years? If yes, please describe.

_____

_____

☐ ☐ Are you taking any of the following?:
Prescribed Medications & Inhalers:_____

_____

_____

Over the Counter, Natural or Herbal Preparation:_____

_____

☐ ☐ Are you taking or have you ever taken Bisphosphonates or any other medications for Osteoporosis or chemotherapy for multiple myeloma or other cancers, Orally or I.V.(i.e. Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia)?_____

☐ ☐ Has your M.D. told you to take Antibiotics prior to having any type of dental procedure?

☐ ☐ Are you allergic to any medications or drugs, latex or iodine? _____

_____

☐ ☐ Have you ever had an adverse reaction to any drugs, anesthetics, sedatives, narcotics, Aspirin, Ibuprofen (Motrin)?

_____

☐ ☐ Have you ever had excessive bleeding that required special treatment?_____

☐ ☐ Have you been diagnosed as having any immunodeficiencies such as Systemic Lupus, HIV or AIDS?_____

_____

☐ ☐ Have you been diagnosed with Liver Disease such as Hepatitis Type A, B or C?_____

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YES NO

☐ ☐ Have you been diagnosed with Diabetes? Is there a history of Diabetes in your family?_____

☐ ☐ Are you on a special or restricted diet of any kind?_____

☐ ☐ Do you use any kind of tobacco? If so, how much?_____per day week month

☐ ☐ Do you use any kind of alcohol? If so, how much?_____per day week month

☐ ☐ Do you have any history of substance abuse or do you currently use recreational drugs?_____

For women: check all that are appropriate: ☐ I am pregnant ☐ I am nursing ☐ I am taking birth control pills

Check all of the following that you may have had in the past or that currently apply to you:

☐ Anorexia or Bulimia	☐ Headaches/Migraines	☐ Neurological Disorders
☐ Arthritis	☐ Heart Arrhythmia	☐ Osteoporosis
☐ Asthma	☐ Heart Murmur	☐ Persistent Cough
☐ Bronchitis	☐ Heart Surgery	☐ Radiation Therapy/Chemotherapy
☐ Cancer	☐ Heart Valve Prosthesis	☐ Received Blood Transfusion
☐ Cardiac Pacemaker	☐ Hiatal Hernia	☐ Recent Weight Loss
☐ Chest Pain Upon Exertion	☐ High Blood Pressure	☐ Recurrent Infections
☐ Chronic Fatigue	☐ History of Cancer	☐ Rheumatic Fever
☐ Colitis	☐ Impaired Kidney Function	☐ Seizures
☐ Congenital Heart Lesion	☐ Impaired Liver Function	☐ Severely Impaired Vision
☐ Connective Tissue Disorder	☐ Irritable Bowel Syndrome	☐ Shortness of Breath
☐ Damaged Heart Valve	☐ Jaundice	☐ Sinus Troubles
☐ Emphysema	☐ Joint Replacement Surgery	☐ Sleep Apnea
☐ Epilepsy	☐ Kidney Disease	☐ Stroke
☐ Esophageal Reflux	☐ Low Blood Pressure	☐ Tachycardia
☐ G.I. Ulcers	☐ Mental Health Problems	☐ Thyroid Problems
☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tuberculosis

Do you have any disease, problem or condition not listed above? Please explain: _____

_____

_____

_____ _____ _____

Signature of Patient or Legal Guardian Date Reviewed By

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health providers keep your medical and dental information private. The HIPAA privacy rule states that health providers must also practice with a written Notice of Privacy Practices. This notice is dated January 2008. The Privacy Practices described will be in effect after this date and until they are replaced. You may obtain additional copies of this Notice upon request.

Uses and Disclosure Information

Treatment Services

We may use or provide your health information to all of our staff members, other dentists, your physicians, and/or other healthcare providers taking care of you. We may also provide mail, phone or electronic contacts as appointment reminders, recommendation of treatment alternatives, information about other health services and/or other office services.

Payment and Operations

We may provide your health information as required to allow for payment for services and participation in quality assurance, disease management, training, licensing, and certification programs.

Marketing

We will not use your health information for marketing purposes without your written consent.

Legal Requirements

We may disclose your health information when required by law.

Patient Rights

You have the right to see your information and receive copies of your records under most circumstances. Your request must be in writing and addressed to the Office Manager. You may be charged for the cost of making copies, staff time and postage. A summary of your health information can also be requested for a fee. You may request a listing of any situations where we or our business associates disclosed your health information

Patient Rights continued

for purposes other than treatment, payment, or other activities for the last six years. You may be charged for costs associated with our response.

Threat to Health and Safety

If abuse or neglect is reasonably suspected we may disclose your health information to the appropriate government authorities.

National Security

Information may be given to authorized federal officials when required for intelligence and national security activities.

Family Members, Friends & Others Involved in Care

At your request, we may disclose your health information to a family member or other person if necessary to assist with your treatment and/or payment for services. Based on our judgement as per 164.522[a] of HIPAA we may disclose your information to these persons in the event of an emergency situation. We also may make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays on your behalf. Your information may be disclosed to assist in notifying a family member, care-giver, or personal representative of your location or condition. You may request that we observe additional restrictions on the disclosure of your information. We are not required to agree to these restrictions but we may do so (except in case of an emergency).

By signing this form, I confirm that I have had the opportunity to receive a copy of the Notice of Privacy Practices.

Print Name: _____Signature: _____Date: _____

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Appointment Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment.
If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance.

Our doctors and hygienists want to be available for your needs and the needs of all our patients.
When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen.
Therefore, there will be a fee of $100.00 if we do not receive a call to cancel an appointment within 24 hours.

Thank you for being a valued patient and for your understanding and cooperation as we uphold this policy.
This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

Acknowledgment of Receipt of Appointment Cancellation Policy

By signing this form I confirm that I have had the opportunity to receive a copy of the Appointment Cancellation Policy.

Print Name: _____Signature: _____Date: _____

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