

WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1

ABOUT YOU

Today's Date: _____

E-Mail Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ Male Female

Birthdate: ___/___/___ Age: ___ SS#: _____

Home Address: _____
Apt/Condo #

Single Married Divorced Widowed Separated

Hm #: (____) _____ Pager / Cell #: _____

Wk #: (____) _____ Ext: _____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

2

SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: (____) _____ Ext: _____ SS #: _____

Birthdate: ___/___/___ DL #: _____

Person Responsible for Account: _____

Wk #: (____) _____ Ext: _____ Hm #: (____) _____

Billing Address: _____

Relationship: _____ SS #: _____

Employer: _____ DL #: _____

3

INSURANCE

Primary Insurance

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Neighbor or Relative not living with you.

His / Her Name: _____ Relation: _____

Wk #: (____) _____ Hm #: (____) _____

Address: _____

City

State

Zip

4

MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

Are you currently under the care of a physician? Yes No

Please explain: _____

CONTINUED ON BACK

Your current physical health is: Good Fair Poor

Do you smoke or use tobacco in any other form? Yes No

Have you had any metal rods, pins or implants? Yes No

Are you taking any prescription / over-the-counter or herbal supplemental drugs? Yes No

Please list each one: _____

Have you ever taken Fosamax, or any other bisphosphonate? Yes No

Have you ever taken Phen-Fen? Yes No

For Women: Are you using a prescribed method of birth control? Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes / Fever Blisters |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol / Drug Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N HIV+ / AIDS |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized for Any Reason |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion | <input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer /Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Lupus |
| <input type="checkbox"/> Y <input type="checkbox"/> N Colitis | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Osteoporosis / Paget's Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease |

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N Latex | <input type="checkbox"/> Y <input type="checkbox"/> N Other |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin | |

Please list any other drugs/materials that you are allergic to: _____

Why have you come to the dentist today? _____

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious/ difficult problem associated with any previous dental work? Yes No

Do you have fears about going to the dentist? Yes No

Have you ever had gum treatment? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

Your current dental health is Good Fair Poor

Do you like your smile? Y N Do your gums ever bleed? Y N

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? Soft Medium Hard

How long do you use a toothbrush before replacing it? _____

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? Yes No If yes, why? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature _____

Date _____

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature _____

Date _____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____

MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical conditions.

Signature _____ Date _____

I have read my medical history dated _____ and confirmed that it states past and present medical conditions.

Signature _____ Date _____

I have read my medical history dated _____ and confirmed that it states past and present medical conditions.

Signature _____ Date _____



CONSENT FORM FOR GENERAL DENTAL PROCEDURES

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre- and post-treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

As with all healthcare treatment, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to the following: Pain, swelling and discomfort after treatment, infection in need of medication, follow-up procedures or other treatment. Temporary, or on rare occasion, permanent numbness, pain, tingling, or altered sensation of the lip, face, chin, gums and tongue along with possible loss of taste. Damage to adjacent teeth, restorations or gums. Allergic reaction to anesthetic or medication. Need for follow-up treatment with a specialist, including surgery.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

Signature _____

Date _____

WELCOME TO GOLD DENTAL, PLLC

We would like to welcome you and your family to our dental practice. Please take some time to review some of our office policies.

1. 24 hours notice must be given to cancel an appointment; a no show fee of \$50.00 will be charged if notice is not given.
2. Patients must make a conscientious effort toward good oral hygiene.
3. Patients must arrive to appointments ON TIME! If you arrive late for your appointment you may be asked to reschedule.
4. Payments for services are due at the time that the services are rendered.
5. Patients must keep our office informed of insurance changes as well as address and phone number changes.

****BILLING STATEMENT POLICY****

Our office policy is that balances must be paid on the date the service is rendered. Any balances not paid within 90 days will incur a \$10.00 per month billing charge. _____

AN EXPLANATION OF DENTAL INSURANCE COVERAGE

In an attempt to make the handling of your claims as smooth as possible, we would like to share with you some information about what to expect in regard to your dental insurance.

NO DENTAL INSURANCE PLAN IS A "PAY-ALL"

Dental insurance should be considered as only a subsidy of dental treatment. Most insurance plans cover from 30% to 50% of the average fee for dental treatment. Some plans provide no coverage at all for certain treatments. Even plans that offer 100% coverage rarely pay for the total amount.

EVERY CASE IS DIFFERENT

The following conditions of your individual policy affect the benefits you will receive against your dental treatment:

- Allowances fixed by the insurance company for certain procedures.
- Yearly deductibles and yearly maximums.
- Dental procedures (such as cosmetic services) which the insurance company does not cover.

Your insurance company will calculate your benefits (the percentage the insurance company will pay) AFTER the above deductions have been made from the total fee.

YOUR INSURANCE BENEFITS ARE NOT DETERMINED BY THIS OFFICE

The percentage that insurance pays is determined by the type of group insurance plan your employer purchases. We can in no way alter the policy or guarantee your payments. To avoid disappointment, we strongly suggest that you contact your insurance company to learn exactly what your policy provides.

As a courtesy to you, we will gladly prepare and submit your insurance claim forms for dental treatment received in this office. However, our dental services are rendered to you, not the insurance company. Therefore, you are personally and directly responsible to us for the obligation of payment of fees. Your insurance company, of course, is responsible to you. That portion of your fee which is not covered by insurance will be estimated by our office manager and mutually satisfactory financial arrangements will be worked out before treatment is started.

Signature _____

Date _____



Gentle care combined with advanced technology
to bring you aesthetic excellence

PATIENT CONSENT/ ACKNOWLEDGMENT FORM

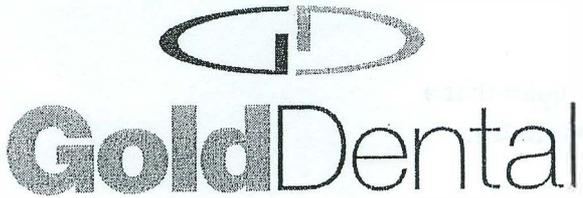
By signing below, you consent to the use and disclosure of your protected health information by Gold Dental, PLLC, our staff and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this office at 845-794-5411 and requesting a revised Notice. We will also post any revised notice in the office.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGMENT.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY.

Name _____ Date _____



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to bring you aesthetic excellence

PLEASE MARK IF ANY OF THE BELOW APPLY TO YOU:

_____ Previous infective endocarditis

_____ Congenital Heart Disease (CHD)*

- Unrepaired cyanotic congenital heart disease, including palliative shunts and conduits
- Completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention during the first six months after the procedure**
- Repaired congenital heart disease with residual defects at the site or adjacent to the site of a prosthetic patch or prosthetic device (which inhibit endothelialization)

_____ Cardiac transplantation recipients who develop cardiac valvulopathy

* Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD

** Prophylaxis is recommended because endothelialization of prosthetic material occurs within 6 months after the procedure.

To accept insurance payments, we now require that a credit/debit card be left on file with our office.

I authorize Gold Dental, PLLC to keep my signature on file and to charge my credit card account for balance of charges not paid by insurance within 60 days and not to exceed \$50.00. We will call on all balances over \$50.00 for authorization before charging your credit card. Any overpayment on the account will be refunded to the same credit card I use for payment.

I assign my insurance benefits to the provider listed above. I understand this form is valid unless I cancel the authorization through written notice to Gold Dental, PLLC and provide alternative payment for committed amount. I understand that this credit card information will not be shared with any outside sources.

Patient Name: _____	
Cardholder Name: _____	
Cardholder Address: _____	Home phone: _____
City, State, Zip: _____	Cell phone: _____
Account number: _____	Expiration Date: _____
Visa / Mastercard / Amex / Discover / Care Credit	CCV _____
Cardholder Signature: _____	

*If you do not leave a credit card on file an 18% billing fee will be added.