

Yorktown Dental Group, LLP

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(914)962-5566

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____

Last

First

MI

Preferred Name

Title: _____ Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: _____ SS#: _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____
Home Mobile Work Ext Fax Other

Address: _____
Address 1 Address 2

_____ City State Zip Code

If Student, Name, City, State of School/College

Whom may we thank for referring you to our practice?

In an emergency who should be notified? Please enter Name and Phone number below:

Emergency Contact: _____

Employment Information

The following is for: the patient the person responsible for payment both not applicable

Employer Name: _____ Phone: _____

Employer Address: _____
Address 1 Address 2

_____ City State Zip Code

Responsible Party Information:

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The following is for: the patient's spouse the person responsible for payment both neither-not applicable

Name: _____
Last First MI Preferred Name

Title: _____ Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: _____ SS#: _____ DL#: _____

Email Address: _____ Best time to call: _____

Phone: _____
Home Mobile Work Ext Fax Other

Address: _____
Address 1 Address 2
City State Zip Code

IF NO INSURANCE, WRITE N/A AND MOVE TO NEXT SECTION

Primary Dental Insurance:

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Address 1 Address 2
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____
Address 1 Address 2
City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

Insurance Address: _____
Address 1 Address 2
City State Zip Code

Insurance Company Phone Number: _____

Secondary Dental Insurance:

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Address 1 Address 2

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

Insurance Address: _____
Address 1 Address 2

City State Zip Code

Insurance Company Phone Number:

Do you have any additional insurance? * Yes No

Insurance Authorization:

By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Dental Information

What is your immediate concern?

Previous Dentist Name and Phone Number:

Date of most recent dental exam and dental x-rays:

Is there anything about the appearance of your smile that you would like to change?

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Check all that apply:

- Had complications from past dental treatment?
- Had trouble getting numb?
- Had any reactions to local anesthetic?
- Had/have braces, orthodontic treatment?
- You experience dry mouth?
- Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth?
- Food gets trapped between any teeth?
- Have you ever whitened or bleached your teeth?
- You have difficulty chewing?
- You clench or grind your teeth?
- You wear or have worn a bite appliance?
- Gums bleed when brushing or flossing?
- Treated for gum disease or were told you have lost bone around your teeth?
- Noticed an unpleasant taste or odor in your mouth?
- Experienced gum recession?
- Had any teeth become loose on their own (without injury)?
- Experienced a burning sensation in your mouth?
- You snore or wake up frequently during the night?
- Erupting teeth very early or very late?
- Primary (baby) teeth removed that were not loose?
- Permanent or extra (supernumerary) teeth removed?
- Supernumerary (extra) or congenitally missing teeth?
- Chipped or injured primary or permanent teeth?
- Any lost or broken fillings?
- Jaw fractures, cysts, infections?
- Any teeth treated with root canals or pulpotomies?
- Frequent canker sores or cold sores?
- History of speech problems or speech therapy?
- Difficulty breathing through nose?
- Mouth breathing habit or snoring at night?
- Frequent oral habits (sucking finger, chewing pen, ect)?
- Teeth causing irritation to lip, cheek or gums?
- Any broken or missing fillings?

- Have you experienced popping and/or clicking of your jaw joint?
- Soreness in jaw muscles or face muscles?
- Have you been treated for "TMJ" or "TMD" problems?

If any of the checked boxes need further explanation, please describe:

Consent for Services and Financial Policy

Thank you for choosing Yorktown Dental Group. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible. Payment is expected at the time of service unless other arrangements have been made before the start of treatment. Payment Option: -NO INTEREST Payment Plans(2) from CareCredit . Allow you to pay over time with NO INTEREST(1) . Convenient, low monthly payment plans(2) also

available . No annual fees or pre-payment penalties For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment(3). Payment for any co-payments or deductibles is expected when treatment is performed. Please be aware that not all insurance carriers allow assignment of benefits to our office. If this is your situation; payment is expected at the time your claims are submitted to your insurance company. A fee of \$26 is charged for any patients who miss or cancel an appointment, without 24 hour notice. Yorktown Dental Group charged \$26 for returned checks. Unpaid accounts that are forwarded to our collection service will be charged a \$35 service fee. If you choose to discontinue care before treatment is completed, a refund will be determined upon a review of your case. Patients are responsible for any fees incurred, i.e. lab fees once treatment has started. If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

* By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

Name and Relationship to Patient:

* By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

* I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.

Signature

Date

Response Date: _____

Medical History

Patient Name: _____

Last

First

MI

Preferred Name

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- | | | | |
|----------------------------------------------|----------------------------------------------|-----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> acne | <input type="checkbox"/> ADHD | <input type="checkbox"/> AIDS | <input type="checkbox"/> Allergy Anesthetic |
| <input type="checkbox"/> Allergy Flouride | <input type="checkbox"/> Allergy Latex | <input type="checkbox"/> Allergy Metal | <input type="checkbox"/> Allergy Nickel |
| <input type="checkbox"/> Allergy Penicillin | <input type="checkbox"/> Allergy Sulfa Drugs | <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Angina | <input type="checkbox"/> Anti-anflamatory | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Asperger | <input type="checkbox"/> Asthma | <input type="checkbox"/> bells palsy | <input type="checkbox"/> Birth Defects |
| <input type="checkbox"/> blood clot in lung | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Blood pressure- high |
| <input type="checkbox"/> Blood pressure- low | <input type="checkbox"/> Bone Disorder | <input type="checkbox"/> Bone Marrow Transpla | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Endocarditis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> fulvestrant | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> heart failure | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Immune System Issue |
| <input type="checkbox"/> Injury to Face/Head | <input type="checkbox"/> Injury to Neck | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Joint problems |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> lung transplant |
| <input type="checkbox"/> Lupis | <input type="checkbox"/> Major Injury | <input type="checkbox"/> Melanoma in lung | <input type="checkbox"/> Mental Health Dis |
| <input type="checkbox"/> Migrains/Headaches | <input type="checkbox"/> Mitral valve pro | <input type="checkbox"/> Mouth Breather | <input type="checkbox"/> MS |
| <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Polio, mononucleosis |
| <input type="checkbox"/> Postural Vertigo | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Speech problems | <input type="checkbox"/> STD- Any | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Swollen Ankles/Feet | <input type="checkbox"/> Swollen Neck Glands | <input type="checkbox"/> Throat Infections | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> Tonsil/Adenoid Cond | <input type="checkbox"/> tourettes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers | | |

Please explain/clarify any conditions or alerts selected above and those not listed, and list any other Allergy or Medications you are currently taking:

Conditions/Alerts:

Do you take antibiotic premedication for your dental visits? If yes, please explain below: * Yes No

Pre-Med:

Are you under medical treatment now? * Yes No

If Yes, please provide appropriate information below:

Name of your Physician and Phone Number:

Name of your Cardiologist and Phone Number

Name of your Oncologist and Phone Number

Preferred Pharmacy and Phone Number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment below:

* By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

Signature

Date

Response Date: _____

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