DENTAL HISTORY

Reason for today's visit

Date of last dental care	Last Dental X-Ray

Former Dentist Telephone ( )

Address City State Zip

Check if you have had problems with any of the following:

☐ Sores or growth in the mouth	☐ Sensitivity to sweets	☐ Bleeding Gums
☐ Food collecting between teeth	☐ Clicking or Popping Jaw	☐ Grinding Teeth
☐ Loose Teeth/Broken fillings	☐ Periodontal Treatment	☐ Bad Breath
☐ Sensitivity to hot or cold	☐ Sensitivity to Biting	

MEDICAL HISTORY

Physician's Name Date of Last Visit

Have you had any serious illnesses or operations? ☐ Yes ☐ No
Have you had any operations involving pins, rods or artificial joints? ☐ Yes ☐ No
If yes to any of the above questions, please explain.

Have you ever had a blood transfusion? ☐Yes ☐ No		If yes, approximate date
Are you pregnant? ☐Yes ☐No	Nursing? ☐Yes ☐No	Birth Control Pills? ☐Yes ☐No

Check if you have or have had any of the following:

☐ Anemia	☐ Epilepsy	☐ Radiation Treatment
☐ Arthritis, Rheumatism	☐ Fainting	☐ Respiratory Disease
☐ Artificial Heart Valves	☐ Headaches	☐ Rheumatic Fever
☐ Artificial Joints	☐ Heart Murmur	☐ Scarlet Fever
☐ Asthma	☐ Heart Problems	☐ Shortness of Breath
☐ Back Problems	☐ Hemophilia	☐ Skin Rash
☐ Blood Disease	☐ Hepatitis	☐ Stroke
☐ Cancer	☐ High Blood Pressure	☐ Swelling of Feet
☐ Chemical Dependency	☐ HIV/AIDS	☐ Thyroid Problems
☐ Chemotherapy	☐ Jaw Pain	☐ Tobacco Habit
☐ Circulatory Problems	☐ Kidney Disease	☐ Tonsillitis
☐ Cortisone Treatments	☐ Liver Disease	☐ Ulcer
☐ Cough, Persistent	☐ Mitral Valve Prolapse	☐ Venereal Disease
☐ Cough up Blood	☐ Osteoporosis	
☐ Diabetes	☐ Pacemaker	

MEDICATIONS

List all medications you are taking:

Allergies

Have you ever been told you need to take Pre Medication for dental visits? ☐Yes ☐No

I certify that all of the information above is correct and up to date.

_____ _____ _____
Signature Printed Name Date

REGISTRATION

PLEASE PRINT AND COMPLETE EVERY SECTION ON EVERY PAGE

Home Phone	Work Phone	Cell Phone	Email Address
( )	( )	( )	

PATIENT INFORMATION

Last Name	First Name	Middle Name

Address	City	State	Zip Code

Sex: ☐ Male ☐ Female	Age	Date of Birth	Social Security No	Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Child ☐ Single ☐ Separated

Employer/School	Occupation

Employers Address	Employers Telephone
	( )

Emergency Contact not living at your address:	Telephone Number
	( )

List all family members that are patients:

RESPONSIBLE PARTY AND INSURANCE INFORMATION

All lines must be filled out

Person responsible for account:

Last Name	First Name	Middle Name

Relationship to Patient	Date of Birth	Social Security Number

Address (if different from patient)	City	State	Zip Code	Telephone
				( )

Employer	Employers Telephone
	( )

Business Address	City	State	Zip Code

Dental Insurance Company	Address	Telephone
		( )

Contract Number	Group Number	Subscriber

ADDITIONAL INSURANCE INFORMATION

All lines must be filled out

Person responsible for account:

Last Name	First Name	Middle Name

Relationship to Patient	Date of Birth	Social Security Number

Address (if different from patient)	City	State	Zip Code	Telephone
				( )

Employer	Employers Telephone
	( )

Business Address	City	State	Zip Code

Dental Insurance Company	Address	Telephone
		( )

Contract Number	Group Number	Subscriber

MEDICAL INSURANCE INFORMATION

As always, we have been working to improve the service we can offer our patients. A new and exciting way we want to help you is by working with your medical insurance. Some dental procedures may be covered by your medical plan. All procedures that qualify will be submitted to your medical insurance plan. To help you with these additional benefits, we will need all of the following information. Also, please present your medical card.

Please read the entire form carefully. If you have any questions, please let us know. If you do not know any of this information at this time, please take this form home and we will provide you an envelope to return it in.

Every Line Must Be Completed For Us To Provide You This Service – Please Print

MEDICAL INSURANCE		
Patient's Last Name	First Name	Middle
Relationship to Subscriber: Self ☐ Spouse☐ Child☐	Date of Birth:	
Subscriber's Name	Date of Birth	Social Security Number
Subscriber's Employer		
Medical Insurance Company		
Address	City	State Zip
Type of Insurance: HMO ☐ PPO ☐ POS ☐ Other:		
Does your insurance company require a referral? Yes ☐ No ☐		
Primary Care Physician		Telephone ( )
Medical Insurance Identification Number		
Insurance Plan or Program Name		
Policy Group Number		

OFFICE POLICIES OF ARLINGTON DENTAL

FEES, BILLING AND INSURANCE:

As a courtesy to our patients, we will be happy to complete any insurance forms. **You must be aware, however, that the ultimate responsibility for the financial obligation lies with you, just as the insurance company's ultimate obligation is to you. Any unpaid balance is your responsibility. Any quote we give you on insurance payment is an ESTIMATE.** If you have any questions regarding insurance or billing, please ask for our insurance or financial secretary. Likewise, if you feel your insurance company is treating you unfairly or inadequately, please seek our assistance.

A list of your specific recommended treatment and fees will be available from the receptionist after your examination. If you're personal circumstances make your dental expenses burdensome, please make us aware of the situation immediately so that suitable arrangements can be made.

APPOINTMENTS:

Occasionally, as in any surgical environment, emergencies or unforeseen delays may arise. We ask for your patience, for we firmly believe in the value of your time. We will try to confirm your appointment as a courtesy, but it is your responsibility to remember the date and time of your appointment.

CANCELLATIONS:

If you cannot keep an appointment, AT LEAST 24 HOURS NOTICE, must be given to cancel the appointment. The courtesy on your part makes it possible to give an appointment to another patient who desires to see the doctors. Any patient, who repeatedly violates this policy, will be subject to a $25.00 per ¼ hour broken appointment fee. Please be aware of the importance of keeping your scheduled appointment, especially prime hours and evenings when many other patients would like to have that time.

You can help us keep down the cost of your dental care by paying for treatment at time of your visit. You will receive an ESTIMATE of the proposed services. A definite financial arrangement should be made in advance of treatment. These options are available for your convenience.

1. Payment may be cash or check at the time of service. There is a $25.00 fee for all returned checks.
2. Visa, MasterCard, Discover, or American express.
3. Professional budget plan. An estimate will be given for work to be done and your portion is due at the beginning of all work.
4. We offer an extended payment plan with prior credit approval from CARECREDIT. (Outside financing company)

Crowns, bridges, dentures, and other laboratory work are fully billed out and payable at the first appointment. If lab work is produced, the patient is responsible for full payment within 45 days of such procedures, whether or not patient schedules the final visit.

I understand and agree that, if this account should be delinquent, I will be responsible for collections and attorneys fee at the rate of one-half of the unpaid balance. I understand I am responsible for any balance on my account. I have read and fully understand the office policies and the payment statement. I certify that I understand English. I have read and agree to the privacy consent form provided by the office. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan to the extent permitted under applicable law. I authorize release of any information relating to claims submitted on my behalf. By signing I agree that if this account should be delinquent, I shall be responsible for collections and attorney's fee computed at the rate of one (1/2) of the unpaid balance.
I authorize insurance payment of all dental benefits otherwise payable to me directly to Ira Stier, DDS, PC.

Signature _____ Print Name _____ Date _____

PATIENT CONSENT FORM

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, payment or health care operations, in order to provide health care that is in you best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal 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 you Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restriction and revoke consent in writing after you have reviewed our privacy notice.

Patient
Name_____Signature_____Date_____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our valued patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

I thank you for being one of our highly valued patients.

SIGNATURE RELEASE STATEMENT

YOUR SIGNATURE IS NECESSARY FOR US TO

1. PROCESS ALL INSURANCE CLAIMS,
2. TO ENSURE PAYMENT FOR SERVICES RENDERED,
3. TO RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES, AND
4. TO RELEASE INFORMATION TO OTHER MEDICAL/DENTAL PROVIDERS, WHEN NECESSARY, FOR YOUR TREATMENT.

I authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care. I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to Dr. Stier. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient_____ Responsible Party_____
(Parent, if minor)

Witness_____ Date_____

Arlington Dental Associates & Ira Stier, D.D.S.
876 Dutchess Turnpike **2 Lafayette Court**
Poughkeepsie, NY 12603 **Fishkill, NY 12524**
(845)454-7023 **(845)896-4977**

Smile Evaluation

Name_____ **Date**_____

1. Do you like the way your teeth look? Yes ☐ No ☐
Explain:_____

2. Are you happy with the color of your teeth? Yes ☐ No ☐
Explain:_____

3. Would you like your teeth to be whiter? Yes ☐ No ☐
Explain:_____

4. Would you like your teeth to be straighter? Yes☐ No☐
Explain:_____

5. Do you have spaces between your teeth that you would like closed?
Yes ☐ No ☐
If so, where? _____

6. Would you like your teeth to be longer? Yes ☐ No ☐
If so, Upper___ Lower____ Both ____?

7. Do you like the shape of your teeth? Yes ☐ No☐
Explain:_____

8. Do you have missing teeth that you would like to replace? Yes ☐ No ☐
Explain:_____

9. Do you have old silver fillings that you would like to replace with tooth-colored fillings?
Yes ☐ No ☐
Explain:_____

10. If you could change anything about your smile, what would you change?

_____

_____