MAHOPAC
DENTAL CARE

FAMILY DENTIST

Billing Information

Name _____ Date_____
Address _____
City _____State _____Zip_____
Home Phone_____ Work Phone _____ Cell Phone_____
Birth Date_____ Marital Status _____ Soc.Sec.#_____-_____-_____
E-mail_____ Sex _____ Local 456: Municipality or Teamsters
Town of _____
Name of Responsible Party_____
Billing Address _____

Referred By_____ Full Time Student? School_____

Primary Dental Insurance

Employee Name _____ Birth Date _____
Soc. Sec # _____-_____-_____Relationship: Spouse Child Self Other
Employer Name_____
Address_____
City_____ State_____ Zip_____ Phone _____

Insurance Company Name _____
& Address _____
_____
Group # _____ Employee ID # _____
Phone _____

Secondary Dental Insurance

Employee Name _____ Birth Date _____
Soc. Sec # _____-_____-_____Relationship: Spouse Child Self Other
Employer Name_____
Address_____
City_____ State_____ Zip_____ Phone _____

Insurance Company Name _____
& Address _____
_____
Group # _____ Employee ID # _____
Phone _____

Survey

How did you hear about us?
TV Ad ___ Internet ___ Personal Referral ___ Doctor Referral ___ Ins. Referral ___ Other _____

If you said "Internet", What did you search? _____ Google ___ MSN ___ Yahoo! ___

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Health History

1. Are you in good health? Yes No
2. Are you currently under medical care? Yes No
    a. Physician's Name _____
    b. Phone # _____
3. Have you been hospitalized in the past 5 years? Yes No
    a. Please Explain _____
4. Have you had any serious illnesses or operations? Yes No
    a. Please Explain _____
5. Please list all Medications you take DAILY:
    a. Name_____ Name _____
    b. Name_____ Name _____
    c. Name_____ Name _____
    d. Name_____ Name _____
    e. Name_____ Name _____
6. Do you have, or have you had any of the following?
    a. Heart Disease? Yes No
    b. High Blood Pressure? Yes No
    c. Blood Disorder or Anemia? Yes No
    d. Rheumatic Fever or Heart Murmur? Yes No
    e. A Subacute Bacterial Endocarditis (SBE) Infection? Yes No
    f. Unrepaired Congenital Heart Defect (CHD)? Yes No
    g. Repaired CHD within 6 mos or one that is still leaking? Yes No
    h. A Heart Transplant? Yes No
    i. Artificial Heart (Cardiac) Valve? Yes No
        1. When was it place _____
    j. Artificial Hip, Knee or Joint Replacement? Yes No
        1. When was it placed? _____
    k. Previous Infection in an Artificial Valve, Hip, Knee or Joint? Yes No
    l. Diabetes? Yes No
    m. Stroke? Yes No
    n. Epilepsy or Seizures? Yes No
    o. Fainting Spells? Yes No
    p. Psychiatric Treatment? Yes No
    q. Cancer or Tumors? Yes No
    r. Venereal Disease? Yes No
    s. Radiation or Chemotherapy? Yes No
    t. Liver or Kidney Disease? Yes No
    u. Hepatitis or Jaundice? Yes No
    v. AIDS or HIV Positive? Yes No
    w. Bleeding Disorder or Prolonged Bleeding? Yes No
    x. Asthma? Yes No
    y. Tuberculosis or Emphysema? Yes No
    z. Do you snore or have sleep apnea? Yes No

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7. Have you ever had an Allergy to any medications? Yes No

   a. Please list all Allergies and type of reaction you had to that medication:
      1. Drug_____ Reaction_____
      2. Drug_____ Reaction_____
      3. Drug_____ Reaction_____
      4. Drug_____ Reaction_____

8. Are you presently taking Aspirin, Coumadin or any Anticoagulant? Yes No
9. Have you ever had a reaction to a Local Anesthetic or Novocain? Yes No
10. Have you ever had an allergy to Nickel or any other Metals? Yes No
11. Do you Smoke, Vape or Chew Tobacco? Yes No
12. Are you currently taking or have you ever taken Fosamax, Zometa, Zoledronate, Aredia or Pamidronate? Yes No
13. Are you Pregnant? Yes No
14. DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED? Yes No
    a. Please Explain _____

Financial Consent for Services

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.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed 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 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 ten (10) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time 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. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

Signature _____ Date_____

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Mahopac Dental Care, PLLC

Acknowledgement of Receipt of Notice of Privacy Practices

* You may refuse to sign this acknowledgement*

I, _____, have

received a copy of this office's Notice of Privacy Practices, available upon request and posted in the waiting room.

_____
Please Print Name

_____
Signature

_____
Date

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
SECTION A: PATIENT GIVING CONSENT

Name:_____
Address:_____
Telephone: _____E-mail_____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request and is posted in our waiting room for you to view. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by asking or contacting:

Contact Person: Eric D. Cook, D.D.S.
Telephone: (845) 628-8196 Fax: (845) 628-2889
E-mail: office@mahopacdentalcare.com
Address: 572 Route 6 Mahopac, NY 10541

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____

Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's

Name:_____

Relationship to Patient:

_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.