Scarsdale Dental Spa

Welcome to our Practice!

Will you please help us by providing us with the following confidential information?

PATIENT INFORMATION:

Date: _____ E-mail Address: _____ Referred By: _____

Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ SS#: _____-_____-_____ Driver's License: _____

Sex: __M____F__ Occupation: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Name: _____ Phone #: _____

Spouse's Name: _____ Occupation: _____

Spouse's Address (if different than above): _____ City, State, Zip: _____

Spouse's Employer: _____ Address, City, State, Zip: _____

In the event that we must contact you for scheduling changes, etc, please indicate the best PHONE NUMBER during business hours to phone you:

Phone number: _____**, Place**_____ **Time:** _____

How did you hear about our office? Please check: _____Internet Search ____Patient referral ____Website ____Cable ____In-Town Other _____

If you were referred whom may we thank for their trust in us? _____

INSURANCE INFORMATION:

Primary Insurance Company : _____ Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Policy Holder Name: _____ Member's ID# _____ Birth date: _____

Group# or Policy # _____

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for the purpose of facilitating the billing and reimbursement, directly to Scarsdale Dental Spa of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously arranged.

Date: _____ **Patient's Signature:** _____

CONSENT:

I hereby authorize Scarsdale Dental Spa to take the necessary X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Scarsdale Dental Spa to make a thorough diagnosis of the patient's dental needs. I also authorize Scarsdale Dental Spa to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier and not between Scarsdale Dental Spa and your insurance company. I fully understand that it is my responsibility only for all dental treatment regardless of insurance coverage.

Patient Signature: _____ Date: _____ Dr. Signature: _____

HIPAA PRIVACY FORM
Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

I, _____, have received a copy/explanation of this office's Notice of Privacy Practices.

_____ (Date}_____
(Signature of Patient and/or Guardian)

(Relationship to Patient) Self or Other: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign
Communications barriers (such as a language barrier) prohibited obtaining the acknowledgment
An emergency situation prevented us from obtaining acknowledgement at time of service
Other (Please specify) _____

Our Business & Financial Philosophy

It is important to us that the quality of our business services matches the quality of our dental care. We want the handling of your account, from the start to be perceived as an extension of the dental care we provide you and your family.

All appointments are exclusively reserved. Therefore, a two-business day notice is required for any change in scheduling for short visits. For any appointment scheduled for 1 ½ hours or more, a one-week notice is required for any changes in scheduling. Our office does not accept answering machine or voice mail messages as a change of scheduling. All appointments are to be handled by our front office team during our regular business hours. We reserve the right to charge a fee of $75 per half hour of reserved treatment time for any changes in schedule without sufficient notice.

Patient's Role

As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment at time of services. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone. So that we may file your insurance claim(s) correctly, we ask all patients to complete our Information and Insurance Form before seeing the doctor as that insures our office of obtaining the correct information to better serve you in regards to your benefits.

Regarding Insurance
We file insurance claims for all patients with insurance benefits. We accept assignment of insurance benefits, however the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you. That balance will be due upon billing.

We very much appreciate your payment upon receipt of services. In the event that your insurance company denies payment of a service, you are responsible for that fee. Any unpaid balance after insurance pays is due within 45 **days.**

WE ACCEPT CASH, CHECKS OR MASTERCARD, VISA, AMERICAN EXPRESS Ask us about EASY PAY OPTIONS
WE OFFER ACCESS TO EXTENDED PAYMENT PLANS WITH CREDIT APPROVAL which I give my consent for a credit check.

I understand that any unpaid balance after 60 days is charged a yearly finance charge of 18%. I further understand that this finance charge is equal to 1.5% of my outstanding balance per month. **I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency. If Scarsdale Dental Spa must take additional steps to collect my account, I will pay ALL cost of collection, including court cost and attorney's fees incurred by Scarsdale Dental Spa. I give consent for any credit check to be completed by Scarsdale Dental Spa should it be deemed necessary.**

I have read the Business & Financial Philosophy. I understand, accept, and agree to this Business & Financial Philosophy.

_____ _____ _____ _____
Signature of Patient or Responsible Party Date Witness for Scarsdale Dental Spa Date

MEDICAL HEALTH HISTORY **PATIENT NAME: _____ Date: _____**

A. CIRCLE YOUR ANSWERS (leave BLANK if you do not understand the question):

1. Yes No Are you in good health?
2. Yes No Has there been a change in your health within the last year? Explain: _____
3. Yes No Have you been hospitalized or had a serious illness in the last 5 years? Explain: _____

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4. Yes No Are you being treated by a physician now? For what? _____

Name of your physician: _____ Date of last Medical Exam: _____

B. HAVE YOU EVER EXPERIENCED?

5. Yes No Chest Pains
6. Yes No Swollen Ankles
7. Yes No Shortness of breath
8. Yes No Recent weight loss, fever, night sweats
9. Yes No Persistent cough, coughing up blood
10. Yes No Bleeding problems, bruising easily
11. Yes No Sinus Problems
12. Yes No Difficulty swallowing
13. Yes No Joint pain, stiffness
14. Yes No Jaundice
15. Yes No Dizziness
16. Yes No Ringing in ears
17. Yes No Frequent Headaches
18. Yes No Fainting spells
19. Yes No Blurred Vision
20. Yes No Seizures
21. Yes No Excessive thirst
22. Yes No Frequent urination
23. Yes No Dry Mouth
24. Yes No Sleep apnea or chronic snoring

C. DO YOU HAVE OR HAVE YOU HAD:

25. Yes No Heart disease
26. Yes No Heart attack, heart defects,
27. Yes No Heart murmur
28. Yes No Rheumatic fever
29. Yes No Stroke, hardening of arteries
30. Yes No High Blood Pressure
31. Yes No TB, emphysema or other lung diseases
32. Yes No Hepatitis, A B C
33. Yes No Stomach problems, ulcers
34. Yes No Diabetes
35. Yes No Mitral Valve Prolapse
36. Yes No HIV positive or AIDS-ARC
37. Yes No Tumors, Cancer
38. Yes No Arthritis, rheumatism
39. Yes No Eye disease
40. Yes No Skin disease
41. Yes No Anemia
42. Yes No VD (syphilis or gonorrhea)
43. Yes No Herpes
44. Yes No Kidney, bladder diseases
45. Yes No Thyroid, adrenal diseases
46. Yes No History of diabetes, heart problems, cancer

D. DO YOU HAVE OR HAVE YOU HAD:

47. Yes No Surgeries _____
48. Yes No Blood Transfusions _____
49. Yes No Artificial Joint _____
50. Yes No Contact Lenses _____
51. Yes No Psychiatric Care _____
52. Yes No Radiation Treatments
53. Yes No Chemotherapy
54. Yes No Prosthetic heart valve
55. Yes No Pacemaker
56. Yes No Birth Control Pills (**Women only**)
57. Yes No Pregnant or nursing **(Women only)**

E. DO YOU TAKE OR HAVE TAKEN:

58. Yes No Recreational drugs
59. Yes No Alcohol
60. Yes No Tobacco in any forms
61. Yes No Phen Phen diet Pills or any other diet pills
62. Yes No Fosamax

F. VITAMINS & MEDICATIONS: _____

_____

_____

ALLERGIES: **LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:**

_____

G. ALL PATIENTS:

63. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

_____

64. Yes No Have you ever been told by a physician or dentist that you need to pre-medicated prior to any dental treatment?

Scarsdale Dental Spa 700 White Plains Road Scarsdale, NY 10583
Tel 914.713.2424 Fax 914.713.1120 www.scarsdaledentalspa.com

DENTAL HEALTH HISTORY

H. Name of your Former Dentist: _____ How long since you were last seen? _____

65. Is keeping your teeth important to you? [Y] [N] If yes, why? _____
66. On a scale of 1-10, 10 being the best, where would you rate your smile?
67. On a scale of 1-10, 10 being the best, where you rate your oral health?
68. Have you experienced any of the following problems:

Bleeding gums [Y] [N],	Sensitivity to Hot & Cold [Y] [N]
Bad Breath or sour taste in mouth [Y] [N]	Snoring [Y] [N]
Burning sensations in mouth [Y] [N]	Food catching between teeth [Y] [N]
Soreness in jaw [Y] [N],	Clenching or Grinding of Teeth [Y] [N]
Is it hard for you to open wide? [Y] [N]	Pain/soreness around ears, eyes, face [Y] [N]
Clicking or popping in jaw [Y] [N]	Stiff neck muscles [Y] [N]
Have you or your parents suffer(ed) from Gum Disease? [Y] [N]	Do you or your parents wear dentures/partials? [Y] [N]
Did you ever wear braces? [Y] [N]	Ever been injured in your mouth or head? [Y] [N]
Oral Surgery of any kind? [Y] [N]	Do you smoke or chew tobacco? [Y] [N]

70. Does having dental treatment make you afraid or nervous? [Y] [N] If yes, what specific things bother you? _____

_____ _____

71. Is the brightness of your teeth important to you? [Y] [N]

72. If you could change anything about your smile which of the following would you want?

Whiter [Y] [N]	Close space or spaces [Y] [N]	Replace chipped teeth [Y] [N]
Replace missing teeth [Y] [N]	Replace old crowns [Y] [N]	Remove silver fillings [Y] [N]
Remove Stains/Spots on teeth [Y] [N]	Excess showing of Teeth [Y] [N]	Replace old plastic filling(s) [Y] [N]
Straighter [Y] [N]	Less Gum showing [Y] [N]	Reshape/resize my teeth [Y [N]

73. Fill in this question for us please: Where do you see your overall oral health and/or your smile in the next 5 to 10 years?

74. **Please circle the following which are important to you when making your dental health decision.**

Convenience	Appearance	Relationship with Dental Team
Finances	Time	Quality of care
What insurance covers	Health	Detailed treatment explanations
Fear or Anxiety	Comfort	Technology

Patient Signature: _____ Date: _____

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