East Islip Dental Care

Gary A. Rosenfeld, DDS
228 East Main Street
East Islip NY 11730
(631)581-8600
svill@eastislipdentalcare.com
www.eastislipdentalcare.com

Chart #. ______
FOR OFFICE USE ONLY

Patient Name: ______ Last ______ First ______ MI ______ Preferred Name

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

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

Email Address: ______ Best time to call: ______

Phone: ______ Home ______ Work ______ Ext ______ Mobile ______ Fax ______ Other

Address: ______ ______
______ City ______ State ______ Zip Code

In an emergency who should be notified? Please enter name and phone number below:

______

How did you hear about us? Please check box and, if applicable, indicate name of referrer: ______

- ☐ 1800Dentist
- ☐ Angie's List
- ☐ Better Business Bureau
- ☐ Billboard
- ☐ DemandForce
- ☐ Dentist/Doctor
- ☐ Dentists.com
- ☐ EastIslipDentalCare.com
- ☐ Facebook
- ☐ Family Member
- ☐ Flyer
- ☐ Friend
- ☐ Google
- ☐ Health Fair
- ☐ Insurance Company
- ☐ Internet
- ☐ Lumineers/Cerinate Site
- ☐ Mailing
- ☐ Movie Ad
- ☐ Newspaper Ad
- ☐ Sign
- ☐ Yellow Pages
- ☐ Yodle Marketing
- ☐ ZocDoc

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Employer Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ________ Phone: ________

Address: ________ ________

________ City ________ State ________ Zip Code

Primary Dental Insurance:

Name of Insured: ________ Last ________ First ________ MI

Insured's Birth Date: ________ ID #. ________ Group #. ________

Insured's Address: ________ ________

________ City ________ State ________ Zip Code

Insured's Employer Name: ________

Employer Address: ________ ________

________ City ________ State ________ Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: ________

Insurance Address: ________ ________

________ City ________ State ________ Zip Code

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Secondary Dental Insurance

Name of Insured: ____________ ____________ ____
Last First MI

Insured's Birth Date: ____________ ID #. ____________ Group #. ____________

Insured's Address: ____________ ____________
____________ ____ ____________
City State Zip Code

Insured's Employer Name: ____________

Employer Address: ____________ ____________
____________ ____ ____________
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ____________

Insurance Address: ____________ ____________
____________ ____ ____________
City State Zip Code

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 East Islip Dental Care will assist me in every way possible with my insurance carrier, but it is not always possible to predict which services are covered by the carrier or how much they will pay for a particular service. I will contact my insurance carrier with any questions regarding coverage. I understand that I am financially responsible for all charges whether or not paid by insurance.

Medical History

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.

- [ ] *Meds - List Below
- [ ] *Pre-Med - Other
- [ ] *Pre-Med Amoxicylin
- [ ] *Pre-Med Clindomycin
- [ ] Allergies
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Hay Fever
- [ ] Allergy - Latex
- [ ] Allergy - Other
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Allergy Erythromycin
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Disease
- [ ] Blood Thinner
- [ ] Cancer
- [ ] Chemo Treatment
- [ ] Chest Pains
- [ ] Diabetes
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Fosamax*d
- [ ] Geographic Tongue
- [ ] Glaucoma
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur MVP
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV/AIDS
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Mental Disorder
- [ ] Nervous Disorder
- [ ] No EPI
- [ ] Other
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] See Medical History
- [ ] Sinus Problems
- [ ] Stents
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Taking Medication
- [ ] TMJ
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

- [ ] Ever been hospitalized (illness or injury)
- [ ] Presently being treated for any other illnesses
- [ ] Taking medication for weight control (ie fen-phen)
- [ ] Taking dietary supplements
- [ ] Subject to frequent headaches
- [ ] A smoker or smoked previously
- [ ] FEMALE: Taking birth control pills
- [ ] FEMALE: Pregnant

If any conditions or alerts selected above need further clarification, please describe below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

What is your estimate of your general health?

- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor

Name of your physician and your most recent physical exam:

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

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin.

* [ ] 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. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. This will serve as my electronic signature.

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of previous dentist and date of most recent dental exam:

Date of most recent dental x-rays:

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most)

Personal History, Check all that apply:

☐ Had an unfavorable dental experience
☐ Had any reactions to local anesthetic
☐ Had your bite adjusted
☐ Had trouble getting numb
☐ Had/have braces, orthodontic treatment
☐ Had any teeth removed

Smile Characteristics, Check all that apply:

☐ Is there anything about the appearance of your teeth that you would like to change?
☐ Have you ever whitened (bleached) your teeth?
☐ Have you felt uncomfortable or self conscious about the appearance of your teeth?
☐ Have you been disappointed with the appearance of previous dental work?

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Bite and Jaw Joint, Check all that apply:

- [ ] You have problems with your jaw joint
- [ ] You have problems chewing
- [ ] Your teeth changed in the last 5 years, become shorter, thinner, or worn
- [ ] Your teeth are crowding or developing spaces
- [ ] You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
- [ ] You clench your teeth in the daytime or make them sore
- [ ] You have problems with sleep or wake up with an awareness of your teeth
- [ ] You wear or have worn a bite appliance

Tooth structure, Check all that apply:

- [ ] Cavities within past 3 years
- [ ] The amount of saliva in your mouth seems too little or you have difficulty swallowing any food
- [ ] You notice or have holes (i.e. pitting, crates) on the biting surface of your teeth
- [ ] Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth
- [ ] Grooves or notches on your teeth, chipped teeth, or had a toothache or cracked filling
- [ ] Food gets caught between any teeth

Gum and Bone, Check all that apply:

- [ ] 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
- [ ] History of periodontal disease in your family
- [ ] Experienced gum recession
- [ ] Had any teeth become loose on their own (without injury), or have difficulty eating an apple
- [ ] Experienced a burning sensation in your mouth

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Consent for Services and Financial Policy

Check the box below indicating your understanding and agreement to our financial policies.

☐ East Islip Dental Care is a provider for many insurance plans and we will be listed in your group's provider list if we are participating in your plan. We will bill your insurance directly and receive payment directly from them. However, to avoid any confusion, be aware that we do expect payment of any applicable deductibles, co-payments or co-insurance at the time of service. Also, any services that your insurance will not cover are your responsibility.

☐ If we are not a participating provider for your insurance plan, you are responsible for your estimated portion and we will bill your insurance directly if you have provided us with complete information to do so. Any payment for our services paid directly to you is due to us upon receipt.

☐ If you do not have insurance payment is expected at the time of service. For your convenience we accept Visa, MasterCard, Discover Card, American Express and debit cards. If payment in full is not possible at the time of service, payment plans are available and can be arranged upon your request.

☐ If you need our doctor to complete forms, there will be a $10.00 fee per page per form to be completed.

☐ Statements are mailed monthly to patients with an outstanding balance. If you are unable to pay your balance within 30 days, please contact us at (631) 581-8600.

☐ A 24-hour advanced notice is required if you must cancel or change an appointment.

*☐ 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,

☐ 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.

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Name of patient, parent, or guardian completing this form:

* ____________________

Relationship to patient:

* ____________________

Response Date: ____________