# Advanced Periodontics & Implant Dentistry of Westchester

280 Mamaroneck Avenue, White Plains, NY 10605 - Phone: 914-997-1111 Fax: 914-946-0559
Info@advancedperio.com

## Patient Information – Please Review and Complete ALL Information on Pages 1 through 4

Patient Name _____ Date: _____
Last, First MI (Preferred Name)

Date of Birth:_____ Gender: M / F Family Status:_____ Social Security #:___-___-____.

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone:_____

Email Address: _____ Preferred Method of Contact: _____

Address: _____ Apartment/Unit:_____
**Street**

City_____State_____Zip:_____

Emergency Contact Name:_____Relation:_____Phone:_____.

**Preferred Pharmacy & Address: _____Phone#_____**

## Health Information – Please Complete in Entirety

Date of Last Dental Visit: _____ Reason for this visit: _____

**Have you ever had any of the following, please check all that apply:**

- ☐ AIDS
- ☐ Allergies(Please List) _____ _____ _____
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Aspirin Therapy
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever(Seasonal)
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ MVP
- ☐ Pacemaker
- ☐ Pregnancy Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Smoker
- ☐ Bisphosphonate

**List of Medications: (Required):**

_____
_____
_____
_____
_____

**Herbal Supplements:**

_____
_____
_____

**Please choose Yes or No:**

- Have you ever had any complications with Local Anesthesia, Getting Numb, Nitrous Gas, or following dental treatment?
  ☐ Yes ☐ No If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care within the last two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Primary Care Physician: _____ Phone: _____
- Do you have **any** medical history or any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor or his care team at the next appointment without fail.

_____ _____
**Signature of Patient, Parent, or Guardian** **Date**

## Referral Information

Whom may we thank for referring you to our practice?
☐Patient, friend ☐Patient, relative ☐Dental Office (list below) ☐Google ☐Newspaper ☐School ☐Work ☐Other

Name of your general dentist **AND** specialty dentist: _____ | _____
OR
Name of person or office referring you: _____

## Insured Party/Insurance Policy Holder Information

Name: _____ ☐ Male ☐ Female Marital Status: M / S / Other

Is the policy holder of insurance a patient here? ☐ Yes ☐ No

Social Security#: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip

## Employer & Dental Insurance Information – Please provide your insurance and photo ID cards

Employer Name (of the insured person): _____

Insurance Name: _____ Insurance Phone #: _____

ID#: _____ Group #: _____

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

## Consent for Services - Office Policies - Patient Rights – HIPPA

**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. If the procedure that I have, or my child has, either been referred for or which we are consulting for can be done today, I consent to it being performed and understand the verbal pre-operative and post-operative instructions given to me. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.**

**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. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.**
**A service charge on the unpaid balances 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. 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.**

**In accordance with the NY State HIPPA & Patient Rights Law I, _____ grant my permission to Advanced Periodontics or your assignees to telephone me at home, at my work, or by email or text to discuss matters related to this form and/or Treatment needed and/or completed and give permission to contact my referring Dentist or Dentist I may be referred to.**
**I agree to the Advanced Periodontics Change/Cancellation Policy: 48 Hours for Consultations and 5 Days for Surgical Appointments. The time is reserved specifically for you and cannot be utilized for other patients. Unfortunately, in order to continue to maintain our high professional standards and control our dental fees it is necessary to charge for appointments which patients fail to keep, without proper prior notice.**

_____ _____
**Signature of patient, parent, guardian** **Date:**