Advanced Periodontics & Implant Dentistry of Westchester

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Patient Information

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

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

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

Email Address: _____ Preferred Method of Contact: _____

Address: _____
Street Apartment #
City State Zip Code

_____

Preferred Pharmacy: _____ **Phone#** _____

Health Information

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

Have you ever had any of the following? Please check those 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

OTHER:

_____
_____
_____

MEDICATIONS:

_____
_____
_____
_____
_____
_____
_____
_____

• Have you ever had any complications with Local Anesthesia, Trouble 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 during the past 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 Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors 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? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other

Name of person or office referring you to our practice: _____

Spouse/Responsible Party/Insured Information

Name _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

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

Address: _____

Street Apartment #

_____

City State Zip Code

Employer & Insurance Information

Primary

Employer Name:_____ Is insured a patient? ☐ Yes ☐ No

Insurance Name: _____ ID #:_____ Group #: _____

Insurance Phone #:_____

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.

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 you or your assignees, to telephone me at home, at my work or by email 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 48 Hour Change/Cancelation Policy. The time is reserved specifically for you and cannot be utilized for other patients. We must insist on 48 hours advanced notice when an appointment is broken. 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 or signature of guarantor/responsible party **Date:**

INSURANCE AND FINANCIALS

We understand that insurance can be confusing. Please know that we are here to help in any way we can, but we do not control what the insurance company will cover or reimburse.
The insurance is an agreement between you, your employer and the insurance company.
We do not dictate how or what the insurance company will pay. We encourage you to become familiar with your policy, exclusions and deductibles. We will always help our patients maximize their benefits, including same day electronic form filing and provide an in depth detailed breakdown of your benefits.

Patients are ultimately responsible for the full cost of treatment, whether or not we accept their Insurance Benefits. The Financials given are an Estimate based off the insurance information provided to us and in the event a Pre Estimate/Determination is submitted on your behalf, it is not a binding contract with your insurance and services once estimated to be covered can be denied.

Once we have your out of pocket due for treatment and you are ready to schedule, ½ of your out of pocket is due to reserve the appointment time and the remaining ½ is due the day of Surgery. Unless same day surgery is complete, in which your of pocket is due in full.

CareCredit is available to patients after a Pre-Arranged discussion and pending qualification with the Care Credit Synchrony Bank. We reserve the right as an office to use Care Credit for specific balances due and interest free periods.

Our expectations of you as the owner of the policy:
1. Payment of fees not covered by your insurance plan at the time the service is rendered.
2. Researching your dental insurance plan to advise you of benefits available to you.
3. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from you insurance carrier.
4. Realize that dental insurance policies restrict payment for some services, use restricted fee schedules (called usual and customary rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance, not our fees or recommended treatment.
5. Keeping our office informed of any changes in your insurance coverage.
6. Taking responsibility for payment if the insurance company does not pay our office.
7. Keeping in mind if you have used CareCredit you are now subject to their payments, rules & regulations.

I hereby authorize benefits to be paid directly to Dr. David L. Sandak or Dr. Fara Vossughi here at Advanced Periodontics & Implant Dentistry.

I understand that I am responsible for any Copayment/Deductible/Unpaid balance. Please choose your payment method.

Visa MasterCard American Express Discover CareCredit

Card Number_____ Exp. Date_____ Zip Code: _____

Print Name: _____ Date_____

Signature: _____ Date_____