*Treating patients like family for **over 40 years**!*
Our goal is to help you reach and maintain your maximum oral health
Please fill out this form completely.
The better we communicate, the better we can care for you!

Passes Dental Care

415 Northern Boulevard, Great Neck, NY, 11021
Tel: 516.487.3131 • Fax: 516-487-9391• www.passesdentalcare.com

ABOUT YOU

Name: _____

I prefer to be called: _____

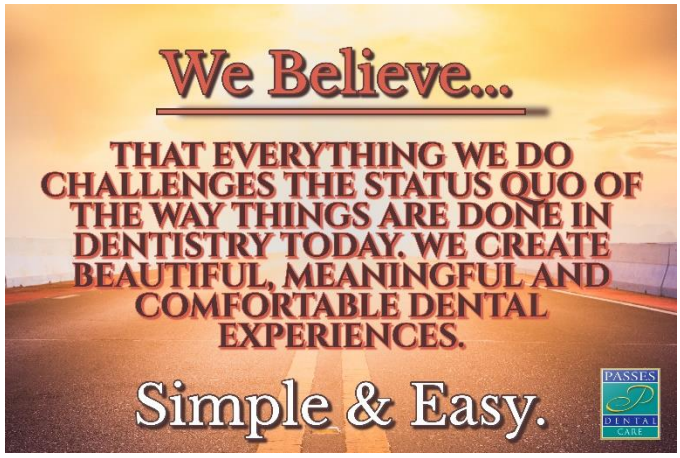
PERSON RESPONSIBLE FOR ACCOUNT

Name: _____
Work #:_____ Ext.___ Home #:_____
Billing Address: _____
_____
Relation: _____ Birthdate: _____

SPOUSE INFORMATION ♥

His/Her Name:_____
Home #:_____ Birthdate:_____
In an event of an emergency, is there someone who lives near you that we should contact?
His/Her Name: _____
Relationship to Patient: _____
Work #:_____ Home #:_____

Welcome to Our Dental Family!



DENTAL HISTORY

Why have you come to the dentist today?
_____
_____
_____
_____
_____

Do you require antibiotics before dental treatment?
☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work?
☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

I have a fear of/ I have concerns about:
☐ Experiencing Pain ☐ Needles ☐ Gagging
☐ Being Embarrassed ☐ Losing my teeth/False teeth

To understand what is going on in my mouth, My preference is:
☐ To know all the details
☐ To be given the bottom line
☐ To read pamphlets
☐ To talk with a team member about solutions to my problems

Do you now have or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?
☐ Yes ☐ No

Your current dental health:
☐ Good ☐ Fair ☐ Poor

How many times a week do you floss?
_____

Do your gums ever bleed?
☐ Yes ☐ No

Type of bristles:
☐ Hard ☐ Medium ☐ Soft

PATIENT MEDICAL HISTORY

Patient's Name: | **Cell Phone:** | **For Office Use Only** ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

For your Appointment Confirmation - Do you prefer: ○ Call ○ Text ○ E-Mail

Are you happy with your smile? ○ Yes! ○ No. I'd like to change:

Whom May We Thank for Referring You:

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

Height:

For Office Use Only
BP | Heart Rate:

Weight:

Y N	Conditions
☐ ☐	Abnormal Bleeding
☐ ☐	Alcohol Abuse
☐ ☐	Allergies
☐ ☐	Anemia
☐ ☐	Angina Pectoris
☐ ☐	Arthritis
☐ ☐	Artificial Bones
☐ ☐	Artificial Heart Valve
☐ ☐	Asthma
☐ ☐	Blood Transfusion
☐ ☐	Cancer- Chemotherapy
☐ ☐	Colitis
☐ ☐	Congenital Heart Defect
☐ ☐	Cosmetic Surgery
☐ ☐	Diabetes
☐ ☐	Difficulty Breathing
☐ ☐	Drug Abuse
☐ ☐	Emphysema
☐ ☐	Epilepsy
☐ ☐	Fainting Spells
☐ ☐	Fever Blisters
☐ ☐	Frequent Headaches

Y N	Conditions
☐ ☐	Glaucoma
☐ ☐	Hay Fever
☐ ☐	Heart Attack
☐ ☐	Heart Surgery
☐ ☐	Hemophilia
☐ ☐	Hepatitis A
☐ ☐	Hepatitis B
☐ ☐	High Blood Pressure
☐ ☐	HIV+ AIDS
☐ ☐	Kidney Problems
☐ ☐	Liver Disease
☐ ☐	Low Blood Pressure
☐ ☐	Mitral Valve Prolapse
☐ ☐	Pace Maker
☐ ☐	Pneumocystitis
☐ ☐	Psychiatric Problems
☐ ☐	Radiation Therapy
☐ ☐	Rheumatic Fever
☐ ☐	Seizures
☐ ☐	Shingles
☐ ☐	Sickle Cell Disease
☐ ☐	Sinus Problems

Y N	Conditions
☐ ☐	Stroke
☐ ☐	Thyroid Problems
☐ ☐	Tuberculosis
☐ ☐	Ulcers
☐ ☐	Venereal Disease
☐ ☐	Yellow Jaundice

Y N	Allergies
☐ ☐	Aspirin
☐ ☐	Codeine
☐ ☐	Dental Anesthetics
☐ ☐	Erythromycin
☐ ☐	Jewelry
☐ ☐	Latex
☐ ☐	Metals
☐ ☐	Penicillin
☐ ☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N Is there any disease, condition, or problem that you think this office should know about that is not covered above?
☐ ☐ **If yes, please describe below...**

POLICIES

Your appointment is reserved and requires a *48 hour notice of cancellation*. We reserve the right to charge a fee of $50 for every ½ hour of missed appointments for this time.

You agree that we may release information to the insurance carrier regarding your records.

Payment is due when services rendered.

All past due accounts of more than 30 days are subject to a 1.5% monthly finance charge.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ THIS ENTIRE FORM, PROVIDED CORRECT INFORMATION, AGREE TO THE CONDITIONS LISTED ABOVE, AND THAT I UNDERSTAND THAT FILING INSURANCE CLAIMS IS THE OFFICE RESPONSIBILITY.

_____ _____

PATIENTS SIGNATURE
(If minor, Parent/Guardian must sign)

DATE

I have reviewed the medical history:

_____ _____

DOCTOR'S SIGNATURE

DATE

PASSES DENTAL CARE

PLEASE COMPLETE THIS FORM FIRST SO WE CAN ALLOW ENOUGH TIME TO COMPLETE YOUR COMPLIMENTARY BENEFIT CHECK.

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Phone Number: _____

Group Number: _____

Insured's Name: _____

Relation: _____

Insured's Birthday: __/__/____

Social Security # _____

Insured Employer: _____

Patients Birthday: __/__/____

School Name if Patient is Attending: _____
Full Time or Part Time *Please make sure your insurance has current records on your student status*

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Group Number: _____

Insured's Name: _____

Relation: _____

Insured's Birthday: __/__/____

Social Security # _____

Insured Employer: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

PASSES DENTAL CARE
415 NORTHERN BLVD.
GREAT NECK, NY, 11021

I understand that under Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers, who may be involved in that treatment directly and indirectly.
- Obtain Payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications

I have received, read and understand the **Notice of Privacy Practices** containing a more complete description of the uses and disclosure of my health information. I understand that the organization has the right to change is **Notice of Privacy Practices** from time to time and that I may contact the organization (The U.S. Department of Health & Human Services) at its toll free number 1-877-696-6775 at any time to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how private my information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature & Date: _____

****

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____