DR. DAVID BRISMAN

Three Generations Of Quality Dentistry

212-673-6900
31 Washington Square West
New York, NY 10011

PATIENT INFORMATION

Patient name_____

Address_____Apt_____

City_____

State _____ Zip _____

Home phone _____Work_____

Cell phone _____

e-mail _____

Social Security Number _____

Sex: M F Date of Birth_____

Married Single Minor Other

Occupation _____

Patient Employer _____

Whom may we thank for referring you?

_____

Emergency contact _____

Phone number _____

HIPPA CONSENT

The dentist may use my healthcare information and may disclose such information to the insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

Signature of patient, parent or guardian Date

CANCELLATION POLICY

I understand that I will be responsible for cancelling any appointments at least 1 business day prior to the appointment or I will be responsible for paying a $50 charge.

_____

Signature of patient, parent or guardian

DENTAL INSURANCE

Who is responsible for this account?

_____

Relationship to patient? _____

Insurance Co _____

Group number_____

Subscriber name _____

Birthday _____SS or ID#_____

Is patient covered by additional insurance?

Subscriber name_____

Birthday _____SS or ID#_____

Relationship to patient?_____

Insurance Co _____

Group number _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents have insurance coverage and I assign directly to the dentist all insurance benefits, if any, otherwise payable to me for services rendered. I authorize use of my signature for all insurance submissions.

_____

Signature of patient, parent or guardian Date

FINANCIAL POLICY

I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that it is up to me to know the details of my insurance. I also understand that the office will gladly work with me and my insurance carrier to maximize my benefits, but ultimately the office's relationship is with me, the patient, and not the insurance company.

By my signature, I acknowledge that I have read and agree to the above.

_____

Signature of patient, parent or guardian

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ALLERGIES (Check all that apply)

	Aspirin		Codeine		Latex		Penicillin		Sulfa		Erytho		Other:

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis: _____

_____

DENTAL HISTORY

Reason for today's visit_____ Date of last dental visit/ dental x-ray_____

HEALTH HISTORY

Have you ever had any of the following? (check boxes that apply)

	AIDS/HIV		Artificial Heart Valves		Artificial Joints
	Asthma		Bleeding Abnormally, with Extractions or Surgery		Blood Disease
	Cigarette, pipe, or cigar smoking		Circulatory Problems		Clicking or Popping Jaw
	Cough, persistent or bloody		Diabetes		Dry Mouth
	Emphysema		Epilepsy		Grinding Teeth
	Gums Swollen or Tender		Heart Murmur		Heart Problems
	Hepatitis Type_____		High Blood Pressure		Loose Teeth or Broken Filling
	Mitral Valve Prolapse		Nervous Problems		Pacemaker
	Radiation Treatment		Respiratory Disease		Sensitivity to Cold
	Sensitivity to Heat		Sensitivity to Sweets		Sinus Trouble
	Tuberculosis		Other:		Pregnancy

Consent for treatment

I give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment

_____

Signature of Patient, parent or guardian Date

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