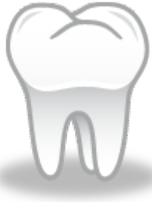

Paul M Hertz DMD
6011 Riverdale Avenue
Bronx NY 10471
(718) 432-9900

Thank you for trusting us with your dental needs. It is our goal to provide you with an experience that will leave you smiling both on the inside and out. Please do not hesitate to ask any questions.

Patient Information

Name ______________________________________ Age_____________ Date of Birth _____________

Social Security # __________________ Sex _____________ Marital Status _____________ Spouse's Name_____________________

Home/Cell Phone _____________ Alternate Phone # _____________ Email Address ______________________________________

Address ______________________________________ Apt _____________ City _____________ Zip Code _____________

Occupation ___________________________ Employer ______________________________ Bus. Phone # _____________

Business Address ______________________________________ Apt _____________ City _____________ Zip Code _____________

In Case of Emergency Contact:

Name ______________________________________ Phone # _____________ Relationship _____________

Whom may we thank for referring you to our office? ______________________________________

Financial Information

Person Financially Responsible ______________________________________ Relationship _____________

If Not You:

Date of Birth _____________ Social Security # _____________

Address ______________________________________ Apt _____________ City _____________ Zip Code _____________

From Insurance Card:

Dental Insurance Name ____________________________________ Phone # _____________

Address ______________________________________ Apt _____________ City _____________ Zip Code _____________

Group # ____________ Is this a PPO? ____________

Medical Information

Physician's Name ______________________________________ Phone # _____________ Last Medical Check-up ___________

Address ______________________________________ Apt _____________ City _____________ Zip Code _____________

Please list any allergies especially to medications and/or latex ____

Do you require any pre medications before dental procedures? Which? ____

Pharmacy ______________________________________ Phone # _____________

Medical History

List all hospitalizations and serious illnesses (with dates) ____

____

Are you taking any prescriptions (prescription or non-prescription)? Please List ____________________________

____

Has there been any change in your general health recently? Please explain ________________________________

____

Do you have or have you ever had any of the following:

Rheumatic fever, rheumatic heart disease, heart murmur	YES	NO
Heart disease, Heart attack, angina, heart surgery, irregular beats, pacemaker, or prosthetic valves		
High blood pressure		
Anemia		
Stroke, convulsions, epilepsy, or fainting spells		
Hay fever, hives or skin rashes		
Allergic reaction to any medication? Which?		
Diabetes		
Thyroid Problems		
Easy bleeding tendency or frequent bruising		
Complications during or following dental treatment		
Arthritis or rheumatism		
Cancer, radiation treatment or Chemotherapy		
Kidney disease or renal dialysis		
Aids		
Hepatitis, jaundice or liver disease		
Breathing problems, asthma, or tuberculosis		
Ulcers		
Persistent cough or sinus trouble		
Bleeding gums		
Are you taking any steroid medications (cortisone		
Psychiatric treatment		
WOMEN: Are you pregnant		

What was the date of your last dental visit? __________ Reason for that Visit ______________________________

Reason for today's visit ____

Do you have any cosmetic concerns about the way your teeth look? ___________________________________

Are there any other major concerns you would like addressed? ______________________________________

Patient Print Name __________________________ Signature __________________________ Date __________

Parent/Guardian Name ________________________ Signature __________________________ Date __________

PAUL M. HERTZ, DMD

6011 RIVERDALE AVENUE

RIVERDALE, N.Y. 10471

TEL (718) 432-9900

FAX (718) 432-9903

PATIENT CONSENT FORM

The department of health and human services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The privacy rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records.

We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you chose not to disclose your Personal Health Information (PHI). If you chose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Patient Print Name ________________________ Signature ________________________ Date ___________

Parent/Guardian Name ____________________ Signature ________________________ Date ___________

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PAYMENT POLICY

IN ORDER TO MAINTAIN OUR FEES AT THE CURRENT LEVEL AND TO CONTINUE THE QUALITY OF CARE THAT WE PROVIDE, IT HAS BECOME NECESSARY TO IMPLEMENT THE FOLLOWING PAYMENT POLICIES:

1. ALL FEES ARE DUE AND PAYABLE ON THE DAY THAT THE SERVICE IS RENDERED. WE ACCEPT CASH, PERSONAL CHECKS, CARE CREDIT AND CREDIT CARDS. ANY ARRANGEMENTS, SUCH AS SUBMITTING TO YOUR INSURANCE COMPANY PRIOR TO MAKING A PAYMENT, MUST BE DISCUSSED AND AGREED UPON BEFORE LEAVING THE OFFICE THE DAY OF SERVICE. IT SHOULD NOT BE EXPECTED THAT CERTAIN ALLOWANCES WILL BE REPEATED EVERY VISIT WITHOUT ANY DISCUSSION.

2. WE ARE VERY CONSCIOUS OF AND RESPECT OUR PATIENTS TIME. WE TRY VERY HARD TO STAY ON SCHEDULE AND MINIMIZE ANY WAIT. BECAUSE WE SCHEDULE ONLY ONE PATIENT PER APOOINTMENT PERIOD IT IS IMPERATIVE THAT THE PATIENT DOES THEIR PART AND SHOWS UP ON TIME.

   ACCORDINGLY, OUR BROKN APPOINTMENT POLICY IS THIS: ANY APPOINTMENT BROKEN - WITHOUT 24 HOURS NOTICE WILL BE CHARGED. AN AMOUNT OF $50 WILL BE CHARGED FOR APPOINTMENTS SCHEDULED FOR LESS THEN ONE HOUR AND $100 FOR APPOINTMENTS SCHEDULED FOR ONE HOUR OR MORE.

3. TREATMENT PLANS INVOLVING ANYTHING SENT TO A LAB, INCLUDING CROWNS, BRIDGES, NIGHTGUARDS, RETAINERS AND DENTURES, REQUIRE HALF OF THE FEE TO BE PAID AT THE TIME THE IMPRESSIONS ARE TAKEN, REGARDLESS OF YOUR COVERAGE. BALANCES ARE DUE BY THE DAY OF INSERTION UNLESS YOU HAVE CREATED AN ACCEPTABLE PAYMENT PLAN WHICH MAY OR MAY NOT INCLUDE SUBMITTING TO YOUR INSURANCE COMPANY FOR PAYMENT.

4. BLEACHING, COSMETIC DENTISTRY AND IMPLANT PROCEDURES MUST BE PAID IN FULL ON THE DAY OF SERVICE. THESE PROCEDURES ARE TYPICALLY NOT COVERED BY INSURANCE. THIS DOES NOT MEAN WE WILL NOT ATTEMPT TO COLLECT FROM THEM IF YOU HAVE REASON TO BELIEVE OTHERWISE.

5. ANY BALANCE REMAINING AFTER PAYMENT BY YOUR INSURANCE COMPANY WILL INCUR A 1 ½ % PER MONTH FINANCE CHARGE IF IT REMAINS UNPAID AFTER 30 DAYS. PLEASE FEEL FREE TO CONTACT US IF YOU BELIEVE YOU HAVE BEEN CHARGED THESE FEES IN ERROR.

I ACKNOWLEDGE THAT I HAVE READ THE ABOVE FINANCIAL POLICY AND AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL FEES INCURRED.

Patient Print Name ______________________________ Signature ______________________________ Date ___________

Parent/Guardian Name ___________________________ Signature ______________________________ Date ___________