Patient History and Information

Name _____ Age____ Birth date_____

Address _____ Home Phone _____

Business Address _____ Bus. Phone _____

Email Address _____

Employer _____ Occupation _____ Spouse's Name_____

Person financially responsible _____ Relationship _____

Address_____ Phone _____

Physician's Name _____ Last medical Check-up _____

Address _____ Phone _____

Dental insurance

Company Name _____ Social Security # _____

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

Medical history

List all hospitalizations & serious illnesses (with dates)

_____ Over _____

Are you taking any medications? (prescription or non-prescription) Yes ___ No ___

If YES, please list _____

Has there been any change in you general healthy recently Yes ___ No ___

If YES, please explain _____

Do you have or have you had any of the following?

1. **Rheumatic fever, rheumatic heart disease, heart murmur Yes ___ No ___**
2. **Heart disease, Heart attack, angina, heart surgery irregular beats, Pacemaker, or prosthetic valves Yes ___ No ___**
3. **High blood pressure _____ Yes ___ No ___**
4. **Anemia _____ Yes ___ No ___**
5. **Stroke, convulsions, epilepsy, or fainting spells _____ Yes ___ No ___**
6. **Hay fever, hives or skin rashes _____ Yes ___ No ___**
7. **Allergic reaction to any medication Which? _____ Yes ___ No ___**
8. **Diabetes _____ Yes ___ No ___**
9. **Thyroid Problems _____ Yes ___ No ___**
10. **Easy bleeding tendency or frequent bruises _____ Yes ___ No ___**
11. **Complications during or following dental treatment ____ Yes ___ No ___**
12. **Arthritis or rheumatism _____ Yes ___ No ___**
13. **Cancer, radiation treatment or Chemotherapy _____ Yes ___ No ___**
14. **Kidney disease or renal dialysis_____ Yes ___ No ___**
15. **Have you ever been tested for AIDS Pos ___ Neg ___ Yes ___ No ___**
16. **Hepatitis, jaundice or liver disease _____ Yes ___ No ___**
17. **Breathing problems, asthma, or tuberculosis _____ Yes ___ No ___**
18. **Ulcers _____ Yes ___ No ___**
19. **Persistent cough or sinus trouble _____ Yes ___ No ___**
20. **Bleeding gums _____ Yes ___ No ___**
21. **Are you taking any steroid medications (cortisone) _____ Yes ___ No ___**
22. **Psychiatric treatment _____ Yes ___ No ___**
23. **WOMEN: Are you pregnant _____ Yes ___ No ___**

Reviewed By _____ Date_____

Patient Signature _____ Date _____

PAUL M. HERTZ, DMD, LC

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 you 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 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.

Print Name _____ Signature _____ Date _____

PAUL M. HERTZ DMD, LC

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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 POLICY:

1. ALL FEES ARE DUE AND PAYABLE ON THE DAY THAT THE SERVICE IS RENDERED. WE ACCEPT CASH, PERSONAL CHECKS, AS WELL AS CREDIT CARDS.

2. PATIENTS WHO HAVE ASSIGNABLE DENTAL INSURANCE MAY DEFER PAYMENT ON THE PORTION OF THE FEE WHICH THE INSURANCE IS EXPECTED TO PAY. ALL DEDUCTIBLES AND CO-PAYS MUST BE PAID IN FULL.

3. TREATMENT PLANS INVOLVING CROWNS, BRIDGES, AND DENTURES REQUIRE THAT ½ OF THE FEE BE PAID AT THE TIME IMPRESSIONS ARE TAKEN, REGARDLESS OF YOUR COVERAGE. BALANCES ARE DUE BY THE DAY OF THE INSERTION UNLESS YOUR INSURANCE HAS AGREED TO PAY THE REMAINDER.

4. BLEACHING AND COSMETIC DENTISTRY PROCEDURES MUST BE PAID IN FULL ON THE DAY OF THE SERVICE. THESE PROCEDURES ARE NOT COVERED BY INSURANCE.

5. IMPLANT PLACEMENT PROCEDURES MUST BE PAID IN FULL ON THE DAY SURGERY IS PERFORMED. THESE PROCEDURES ARE USUALLY NOT COVERED BY DENTAL INSURANCE.

6. ANY BALANCES REMAINING AFTER PAYMENT BY YOUR INSURANCE COMPANY WILL INCUR A 1 ½% PER MONTH FINANCE CHARGE IF AFTER BEING BILLED TO YOU THEY REMAIN UNPAID FOR 30 DAYS.

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

SIGNATURE_____ DATE_____