Cummings Family Dentistry

Cosmetic and Family Dentistry

Patient Acquaintance Form

Name_____Address_____

City_____State____Zip Code_____Marital Status_____

Home Phone_____Work Phone_____

Cell Phone_____

Birthdate_____Social Security_____Sex (M/F)_____

Referred By_____

E-mail Address_____

Name of Responsible Party_____

Billing Address_____

Insurance (Y/N)____Employer's Name_____Phone_____

Employer's Address_____Phone_____

Insurance Co Name & Address_____

Insurance Co Phone_____

List any drugs that you are presently taking_____

_____

Pharmacy Name_____Phone_____

In case of an emergency, notify_____Phone_____

Patient
Signature_____Date_____

Dental History

Reason for visit_____

When was your last dental visit?_____

Previous dental office_____

How often do you brush your teeth?_____

What texture toothbrush do you use? ☐soft ☐medium ☐hard

	yes	no
Do your gums bleed while brushing?	☐	☐
Do your gums bleed while flossing?	☐	☐
Do you feel pain to your teeth when brushing or flossing?	☐	☐
Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?	☐	☐
Have you noticed any loosening of your teeth?	☐	☐
Does food tend to become caught between your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Have you ever experienced any of the following:		
Clicking?	☐	☐
Pain (joint, ear, side of face)?	☐	☐
Difficulty opening or closing?	☐	☐
Have you ever had any head, neck, or jaw injuries?	☐	☐
Do you clench your teeth while awake or asleep?	☐	☐
Have you ever had:		
Orthodontic treatment (braces)?	☐	☐
Oral surgery?	☐	☐
Gum treatment?	☐	☐
Your teeth ground, or bite adjusted?	☐	☐
Worn a bite plate or other appliance?	☐	☐
Are you satisfied with the appearance of your teeth?	☐	☐
WOULD YOU LIKE WHITER TEETH? Ask us about tooth whitening options!	☐	☐
Would you like straighter teeth? Ask us about the new **INVISALIGN** method.	☐	☐

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	yes	no
Are you in good health?	☐	☐
Have their been any changes in your general health within the past year?	☐	☐

Date of you last physical exam _____

Physician's name_____

address & phone number_____

Are you now under the care of a physician?	☐	☐
Have you ever been hospitalized for any surgical operation, or serious illness?	☐	☐

Please explain_____

(continued on reverse side)

Medical History Continued...

	yes	no
Are you taking any medicine(s) including non-prescription medicine?	☐	☐
If yes, what medicine(s) are you taking ?_____		
_____		
Have you ever required a blood transfusion?	☐	☐
Do you use tobacco?	☐	☐
Do you use alcohol, cocaine or other drugs?	☐	☐
Do you have any disease, condition or problem not listed above that you think I should know about?	☐	☐

Women only:

Are you pregnant, or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

	yes	no		yes	no
Are you allergic to or have you had reactions to:					
Local anesthetics like Novocain?	☐	☐	Pacemaker?	☐	☐
Penicillin or other antibiotics?	☐	☐	Heart surgery?	☐	☐
Sulfa drugs?	☐	☐	High blood pressure?	☐	☐
Barbiturates?	☐	☐	Low blood pressure?	☐	☐
Sedatives or sleeping pills?	☐	☐	Hepatitis or jaundice?	☐	☐
Aspirin?	☐	☐	Liver disease?	☐	☐
Iodine?	☐	☐	Kidney trouble?	☐	☐
Other?	☐	☐	Tuberculosis?	☐	☐
Do you have or have you ever had the following:			Persistent cough?	☐	☐
Rheumatic fever?	☐	☐	Cancer?	☐	☐
Scarlet fever?	☐	☐	Epilepsy?	☐	☐
Leukemia?	☐	☐	Sinus trouble?	☐	☐
Arthritis or rheumatism?	☐	☐	Fainting spells or seizures?	☐	☐
Heart defect or heart murmur?	☐	☐	Sexually transmitted disease?	☐	☐
Heart trouble, heart attack, or angina?	☐	☐	Joint replacement or implant?	☐	☐
Do you have pain in your chest upon exertion?	☐	☐			
Are you ever short of breath after mild exercise?	☐	☐			
Do your ankles swell?	☐	☐			

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

	yes	no		yes	no
Asthma or hay fever?	☐	☐	Stomach ulcer?	☐	☐
Lung or breathing problems?	☐	☐	Allergies?	☐	☐
Hives or skin rash?	☐	☐	Thyroid problems?	☐	☐
Stroke?	☐	☐	AIDS or HIV infection?	☐	☐
Diabetes?	☐	☐			

I certify that the information listed here is complete and accurate.

X_____DATE_____

(patient, parent or guardian)

Johnasina Cummings D.D.S.
42 High Street
Huntington, New York 11743
(631) 425-1650

PHARMACY INFORMATION

Date: _____

Pharmacy Name: _____

Address: _____

_____

Pharmacy Phone No: _____

Patient Name: _____

Cummings Family Dentistry
42 High Street
Huntington, NY 11743

OFFICE/FINANCIAL POLICY

Thank you for choosing our practice to serve your dental needs. Our office is dedicated to providing optimal care for every patient in the most economical way possible. The following is a statement of our office/financial policy. Please take the time to read the following, initial each section, and sign and date the bottom of this form.

_____ If you do not have dental insurance, payment is expected at the time of service for treatment performed that day unless prior arrangements have been made.

_____ We will file an insurance claim on your behalf as a courtesy to you; however, you must supply, prior to treatment, all the necessary information for filing.

_____ Any deductible as well as any estimated percentages your insurance coverage does not cover, are to be paid of the date of the treatment.

_____ I understand that composite fillings may be downgraded to amalgam and agree to pay the difference of fee.

_____ We will make every effort to follow up on outstanding insurance claims to make sure they are paid in a timely matter. However, if your insurance company has not paid their liability in full within 60 days, the balance then becomes the patient's liability.

_____ For patients whose insurance company pays them directly, payment is expected on the date of treatment

_____ Finance charges of 1.5% per month will be applied to balances over 60 days old.

_____ Long term payments may be available, We have information on several companies that offer this service and we can help you with the details. (This would allow you to make monthly payments spreading those payments over a desired period of time.)

_____ We accept cash, checks, Visa, MasterCard and Discover for payment. We also offer Care Credit for those who qualify, please speak with our appointment coordinator for information and an application.

_____ A courtesy of 24 hour notice is required to reschedule appointments. Please call (631) 425-1650. A $50.00 missed appointment fee may be levied without a 24 hour notice.

_____ For any dental visit 2 hours or longer, we require that the patient leaves a nonrefundable deposit toward their copays and deductible for that visit at the time the appointment is scheduled.

_____ We reserve this appointment time just for you. We value your time and strive to see all patients in a timely manner. We ask that you arrive on time for your appointment.

_____ Return checks may incur a $50.00 service charge.

_____ If you have a dental emergency and the office is not open, you may contact Dr. Cummings at (631) 560-6359.

Again, please feel free to ask any questions that you may have regarding this policy. We are most willing to help you in any way we can.

I HAVE READ THIS OFFICE POLICY AND UNDERSTAND AND AGREE TO THE TERMS OF THIS POLICY.

x_____ Date: _____

Signature of Patient/Responsible Party

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I _____ have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Sign: _____

Date: _____

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself. I, _____ authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____

{Please Print Name} Relationship

_____

{Please Print Name} Relationship

_____

{Please Print Name} Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____