Madison Dentistry

424 Madison Avenue
15th Floor
New York, NY 10017
(212)753-7400

Chart #: ___________
FOR OFFICE USE ONLY

Patient Information

Patient Name: ____ Date: ___________
Last, First MI (Preferred Name)

Gender: ______________ Family Status: _______________

Social Security #: ______________________________ Birth Date: ____________________________

Phone (Home):___________________ (Work):__________________ Ext:__ Mobile:_______________________

E-mail Address: ____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: __________________ Reason for this visit: ____________________________

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies ___________ ___________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:__________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
- ☐ __________________
- ☐ __________________

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: _________________________________ Phone: __________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ____________________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other ___________________

Name of person or office referring you to our practice: ____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): ____________ (Work): ____________ Ext: _____ Best time to call: __________

Address: ______________________________

Street Apartment #

____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________ Occupation: ______________________

Address: ______________________________

Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ____________ ID #: ______________ Group #: ______________

Insured's Address: ______________________________

Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ______________________________

____

Secondary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ____________ ID #: ______________ Group #: ______________

Insured's Address: ______________________________

Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ______________________________

____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: __________ Relationship to Patient: ______________

Signature of patient, parent or guardian

______________________________ Date: __________ Relationship to Patient: ______________

Signature of guarantor of payment/responsible party

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Patient HIPAA Consent Form

I understand that I have certain rights regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) this provides a safeguard to my privacy.

To the best of my knowledge, the information given on the Welcome Forms is complete and correct. I understand that it's my responsibility to inform my doctor if I, or my minor child ever have a change in health.

I certify that I, and/or my dependent(s) have insurance coverage with the insurance company(ies) listed on the Welcome Forms and assign directly to the Doctor also listed on the Welcome forms all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charged whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The Dentist (Doctor) listed on my Welcome Forms may use my health care information and may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payment services and determining insurance benefits payable for services.

I understand that Dentistry, like other medical services are not an exact science and that, therefore, reputable practitioners cannot guarantee results. However, the Doctors do guarantee that they will use all of their experience, skills and technology to provide me with the best dental care. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

PRINT Name of Patient: Date

____ ______________

SIGNATURE of Patient (or Guardian) Date

____ ______________

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Practice Policy

Cancellation/ No Show Policy for Doctor Appointment:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "FULL" appointment book.

* **If an appointment is not cancelled at least 24 hours in advance you will be charged a $50 fee; this is not covered by your insurance company.**

Scheduled Appointments:

We understand that delays can happen, however, we must try to keep all patients and doctors on time.

* **If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.**

Cancellation/ No Show Policy for Surgical Procedures:

Due to the large block of time needed for surgical procedures, last minute cancellations can cause problems and added expenses for the office.

***If surgery is not cancelled at least 48 hours in advance you will be charged a $75 fee; this is not covered by your insurance company.**

Account Balances:

We will require that patients with self pay or insurance balances do pay their account balances to $0 prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may speak to a business office representative with whom they can review their account and concerns. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

Reserving appointments:

In order for a procedure (other than a cleaning) to be scheduled, we ask for a reservation fee for procedures that will last more than one hour.

______________________	______________________	___/___/____
Print Name	**Patient or Guardian Signature**	**Date**

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Payment Arrangements

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENTS ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT

We now offer the following payment options:

___ Check ___ Credit Card ___ Automatic monthly billing to your credit card.
___ Guarantee any amount not covered by insurance with credit card.

Credit Card Information:

I authorize ____________________________ to keep my signature on file and charge my credit card.

____ all visits

_____Recurring charges (on-going treatments)
Amount $ __________ On this Date __________ Frequency _______
Card Holder name _____________________________
Patient Name _________________________________
CC #________________________________ Exp Date ________ CVC _____
Note:

Signature _____________________________ Date____________