Locust Valley Dentists
5 Weir Lane
Locust Valley, NY 11560
516-759-2288

Patient Information and Medical History

Name: ____ Male Female
Last First MI
Title: Dr. Mr. Mrs. Ms. How do you wish to be addressed?:______________
Address:____
Mailing Address City State Zip Code
Home Phone: ___________________ Work Phone: __________________ Cell Phone: ______________
Employer: ________________________________Email Address: _________________________________
Date of Birth: _________________________ Social Security:___________________________________
Who may we thank for referring you to our practice?____

Dental Insurance Information

Employee/Subscriber Name: ____
Last First MI
Date of Birth: ____________________________________ Subscriber ID #: ________________________
Group/Employer: _________________________________ Group Number: __________________________
Carrier Name: _____________________________________ Telephone #:__________________Claim____
Mailing Address: ______________________
____

- I authorize release of any information concerning my/my child's health care recommendations and treatment for the purpose of evaluation and administering claims for insurance benefits.
- I authorize payment of insurance benefits directly to Locust Valley Dentists.
- I understand that my dental insurance benefits may be less than the fees for dental services and may not pay the fee charged in full.
- I understand that I am responsible for and agree to pay the total fees for my/my child's dental treatment.
- I agree to pay any applicable deductible and estimated copayments on the date the dental services are rendered. I understand that not all dental treatment received may not be covered by my insurance plan and I agree to pay for any non-covered services on the date the dental services are rendered.
- I agree to pay the total cost of dental services rendered on the date of services if I/my child does not have dental insurance benefits.

Patient/Guardian Signature: ___________________________________ Date: _______________________

Medical Questionnaire

Patient Name: _______________________________ Date: _____________________________

Please circle if you have any of the following problems:

AIDS/HIV	Alcoholism	Allergies	Anemia
Arthritis	Artificial Joints	Artificial Heart Valves	Cancer
Asthma	Back Problems	Blood Disease	Cough
Chemotherapy	Circulation Problems	Cortisone Treatments	Food Allergies
Diabetes	Epilepsy	Fainting	Heart Murmur
Glaucoma	Headaches	Eating Disorders	Hepatitis A B C
Heart Problems	Hemophilia	Herpes	Liver Disease
High Blood Pressure	Jaw Pains	Kidney Disease	Psychiatric Care
Mitral Valve Prlps	Nervous Problems	Pacemaker	Seizure Disorders
Radiation Tmnt	Respiratory Disease	Rheumatic Fever	Stroke
Shingles	Shortness of Breath	Skin Rash	Tobacco Use
Surgical Implants	Swelling	Thyroid Problems	
Tuberculosis	Ulcers/Colitis		

Known Allergies:

Local Anesthetic	Aspirin
Penicillin	Codeine
Sulfa	Iodine
Latex	Other: _____

Current Medications:________________________
____
Pre-Med Required? ________
Consulting Physician: _______________________
Pharmacy: ________________________________

Have you had any problems with the following?

Bad Breath	Bleeding/Sensitive Gums	Clicking or popping jaw
Food traps	Grinding or clenching teeth	Loose teeth
Broken fillings	Periodontal treatment	Sensitivity to cold
Sensitivity to hot	Sensitivity to sweets	Sensitivity to biting
Sores in mouth	Staining	

Authorization: I have reviewed the information and answered all questions to the best of my knowledge. I understand this information will be used to determine the dental treatment I receive at this office and may be shared with other medical offices as necessary. I will notify the office should any information change in the future.

Signature of patient or guardian: ____________________ **Reviewed by**: ___________________

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Patient Consent Form
(HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most recent copy of this notice.

I understand that I have the right to request restrictions on how my protected health information s used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of __________, 20__

Print Patient Name: _____________________

Relationship to Patient: ______________________

Signature: _____________________________________

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General Consent for Dental Treatment

I understand the purpose of this general consent is to raise my awareness of risks that are commonplace in many dental procedures. I understand my dentist reserves the right where appropriate (for example: for root canal therapy, extractions and other oral surgery, treatment of gum disease, placement or restoration of implants, crowns, bridges, and dentures) to provide me with a more specific informed consent discussion.

I understand that every dental patient has the right to informed consent. That means that as a patient or as a legal guardian for a patient, I should understand what treatment is being proposed, what the possible complications and risks are, and what the alternatives are to the treatment. Of course, one alternative for me is to do nothing, although that carries with it its own risks.

My signature below confirms that I understand that no dental treatment is completely risk free, and that my dentist will take reasonable steps to limit any complications of my treatment and to provide competent dentistry with comfort and care.

I understand that some after-treatment effects and complications tend to occur with regularity.

For routine fillings and dental cleanings, prescription of medications, I understand that includes but is not limited to: temporary soreness, temperature sensitivity, and unusual reactions/allergy to medications given or prescribed. Also, medications have common side effects that are listed by the manufacturer. Further, if I am taking other medications, my dental medications could have an adverse interaction, and I need to fully disclose all my medications to the dentist and pharmacist. This includes herbal supplements.

For the administration of local anesthetic, I understand that for many treatments and procedures I will be given local anesthetic injection and that in a certain percentage of cases patients can have an allergic reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. For oral surgery, I understand that there is always a risk of a post-operative infection, nerve damage, and iatrogenic injury. In rare cases, the complications from surgery can be permanent, disabling, or even cause death. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

I understand that all treatment and procedures have a risk of separation of dental instruments which may become lodged in a gum or other soft tissue or aspirated. Should I experience any of these or other conditions during or following treatment, I will contact my provider as soon as possible.

I understand that the practice of dentistry is not an exact science, and my dentist offers no guarantees or assurance as to the outcome or results of treatment or surgery.

I have the right to ask my provider for more information if I have any concerns about my procedures and the possible side effects or complications, I promise to use that right to its fullest intent if for any reason I feel I am not fully informed about my procedure, the risk of the procedure, and my alternative to the procedure.

Patient/Guardian Signature: ________________________________ Date: ____________________________

Locust Valley Dentists

Financial Agreement

Locust Valley Dentists is committed to providing you with the best dental care available. Our philosophy in serving people is to be informative, honest, and forthright. We have found that a clear understanding of our office financial policies relieves some of the anxiety associated with going to the dentist. We want to be certain that our policies are clear and that all of your questions are answered to your satisfaction. If you have any questions or concerns about our Financial Agreement, please do not hesitate to ask our office staff.

Payment Options

Payment is due at the time treatment is rendered. We accept cash, checks, and all major credit cards.

Dental Insurance

We work with all dental insurance plans (PPO plans) as a courtesy to our patients, but you are responsible for our fees and not what your insurance company allows or considers “usual, customary and reasonable,” all of which vary from one insurance company to another.

We will make a Good Faith estimate for planned treatment but are not responsible for the accuracy of your insurance benefits. There may be a difference between the estimated portion and actual payment. As a service to you, we will complete and file the appropriate forms with your insurance carrier(s). We are happy to provide any x-ray or additional information they may require in order to help maximize your benefits.

After dental insurance has paid their portion, a statement is sent to your mailing address on record for the remaining balance. Payment in full is expected within 30 days of the statement date. If your insurance denies your claim coverage or delays payments beyond 60 days from the claim filed date, the entire amount will become dye and payable by you. Although we make every effort to help you obtain your full benefit, there are many variables we cannot anticipate.

Overdue Balances and Returned Checks

An account with an unpaid balance past 90 days will be sent to a collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt, including finance charges applicable to your outstanding balance. Additionally, a $25 charge applies when a check is returned by the bank.

Broken or Missed Appointments

Your appointment is specifically reserved for you. Broken appointments prevent others from receiving the dental care they deserve. We take them seriously so please be considerate and inform us in advance if you need to change your appointment. Kindly give us 48 business hour notice if you need to make changes to your appointment. There is a $75 cancellation fee for missed appointments and appointments cancelled within the 48 hours.

Consent and Authorization

I authorize payment to be made directly to Locust Valley Dentists by my insurance company and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical care information requested by my insurance carriers. I hereby agree that in the event of default of any amount due and if this account is placed with a collection agency or attorney for collection or legal action, to pay additional charge equal to the cost of collection including any attorney or collection agency fees, applicable finance charges and court costs uncured and permitted by laws governing these transactions.

Signature: ________________________________ Date: ______________________________

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Consent for Internet Communications

I grant my permission to Locust Valley Dentists, and/or such associates or assistants to upload and store confidential patient information (including account information, appointment information, and clinical information) to the secured website for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of and ID and password assigned to me: and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered because of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice website with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements, impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times, during the terms of this agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand the dental practice CANNOT, AND DOES NOT, ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED, OR RECEIVED USING THE SITE OR SERVICES.

I have read the information above regarding the secured uploading or patient information to the website for the dental practice and grant the dental practice permission to securely upload my patient information to the website.

Patient Name: ______________________________ Date: ________________________________

Signature: _______________________________________

(Patient, legal guardian, or authorized agent of patient)

Relationship to patient: ____________________________