ROTHSTEIN DENTISTRY

Restorative & Implant Dentistry

PATIENT INFORMATION

Today's Date:_____Name:_____Male:____Female:____

SSN:_____Birthdate:_____Minor:___Single:___Married:___Partner:___

Address:_____City:_____State:_____Zip:_____

Home Phone: _____Cell Phone:_____ Other:_____

E-Mail: _____Who can we thank for referring you?_____

PRIMARY INSURANCE

Subscriber: _____SSN: _____Birthdate: _____

Relationship to Patient: _____Address: _____

City: _____State: _____Zip: _____ Phone: _____

Insurance Co: _____Group#: _____Employer: _____

SECONDARY INSURANCE

Subscriber: _____SSN: _____Birthdate: _____

Relationship to Patient: _____Address: _____

City: _____State: _____Zip: _____ Phone: _____

Insurance Co: _____Group#: _____Employer:_____

ASSIGNMENT & RELEASE

I hereby authorize payment directly to Dr. Michael Rothstein for all insurance benefits otherwise payable to me for services rendered. ***I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.*** I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature in all insurance submissions.

Responsible Party Signature: _____Date: _____

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HEALTH HISTORY

Name:_____Date:_____

Physician's Name:_____ Phone#:_____Date of Last Visit:_____

Emergency Contact:_____ Phone#:_____

PLEASE CHECK ALL THAT APPLY

__AIDS/HIV+
__Anemia
__Arthritis, Rheumatism
__Artificial Heart Valves
__Artificial Joints
__Asthma
__Blood Disease
__Cancer
__Chemotherapy
__Diabetes
__Epilepsy
__Fainting or Dizziness
__Frequent Headaches
__Heart Problems or Murmurs
__Hepatitis-Type_____
__Herpes
__High or Low Blood Pressure
__Kidney or Liver Disease
__Mitral Valve Prolapse

__Nervous Problems
__Pacemaker
__Prolonged Bleeding
__Psychiatric Care
__Radiation Treatment
__Rheumatic Fever
__Shortness of Breath
__Sinus Trouble
__Skin Rash
__Smoker
__Stroke
__Swelling of Feet/Ankles
__Thyroid Problems
__Tuberculosis
__Ulcer
__Xerostomia (dry mouth)
__Other
_____
_____

Allergies to the Following:
__Local Anesthetics
__Penicillin
__Sulfa Drugs
__Barbiturates (sleeping pills)
__Sedatives
__Aspirin
__Other_____

If Female, are you:
__Pregnant?__Nursing?
__Taking Birth Control?

Are you:
__Being treated for an illness?
__Taking medication? List:
_____
_____

DENTAL HISTORY

Former Dentist_____City/State_____Date of last visit_____

Date of last Dental X-Rays_____ How often do you Brush?_____ Floss?_____

Please check all that apply:

__Bad Breath
__Bleeding Gums
__Clicking or Popping of Jaw
__Gags Easily
__Grinding or Clenching Teeth
__Jaw, Head, or Neck Injuries
__Loose Teeth or Broken Fillings
__Orthodontic Treatment
__Periodontal Treatment
__Sensitivity to Hot___Cold___
__Sensitivity to Sweets
__Sores on Lips or Mouth
__Tooth Pain
__Other
_____

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PAYMENT, FINANCIAL, & INSURANCE INFORMATION

We appreciate the opportunity to serve you. It is our intention to provide you with the finest care possible, while ensuring that you fully understand procedures, treatments, and payment expectations.

We ask that all payments be made on the day of treatment. For your convenience, we accept check, cash, Visa, MasterCard, and Care Credit. If you require extended payments please ask the front desk for options available.

INSURANCE: We will do our best in assisting you to understand your insurance; however, it is not the responsibility of this office to know the specifics of your plan. **We strongly advise you to be aware of any restrictions and all details associated with your insurance policy.** Difficulty obtaining insurance payment may occur, and **insurance payments CANNOT be guaranteed. Remember, you are financially responsible for treatment not covered by your insurance.** If you have any questions, we would appreciate your prompt inquiry.

I have read and understand the above information_____**(please initial)**

SCHEDULING INFORMATION

Staying on schedule is important to us because everyone's time is valuable. Except in emergency situations, you can expect us to be on time for you, and we will appreciate the same courtesy. Your appointment time is reserved specifically for you. If the need arises to reschedule your appointment, please provide us at least 24 hours notice. Without adequate notification we will not be able to give your appointment time to another patient in need of dental care. **There is a $75.00 broken appointment fee for appointments cancelled with less than 24 hours notice.** This fee covers the room preparation charge and the idle time of the doctor, hygienist, and dental assistant that were on duty to provide your personalized care.

If your schedule does not permit you to plan in advance, we might suggest placing you on our list of patients to call on a short notice basis. If you have any questions, we would appreciate your prompt inquiry.

I have read and understand the above information_____**(please initial)**

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT

We keep a record of the health care services we provide to you. You may ask to see and obtain a copy of that record by contacting our Office. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. Our Notices of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____

Patient or Legal Guardian Relationship Date