# Welcome

*Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.*

**Email** ______________________

**Cell Phone** ______________________

Patient # ______________

Soc. Sec. # ______________

Date ______________

## Patient Information (CONFIDENTIAL)

Name ______________________ Birthdate ____________ Home Phone ______________

Address ______________________ City ____________ State/Prov. ________ ZIP/Post. Code ________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School / College ______________________ City ____________ State/Prov. ________ ☐ Full Time ☐ Part Time

Patient's or Parent's Employer ______________________ Work Phone ______________

Business Address ______________________ City ____________ State/Prov. ________ ZIP/Post. Code ________

Spouse or Parent's Name ______________ Employer ______________ Work Phone ______________

Whom May We Thank for Referring You? ______________________

Person to Contact in Case of Emergency ______________________ Phone ______________

## Responsible Party

Name of Person Responsible for this Account ______________________ Relationship to Patient ______________

Address ______________________ Home Phone ______________

Driver's License # ______________ Birthdate ______________ Financial Institution ______________

Employer ______________________ Work Phone ______________ SSN# ______________

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check ☐ Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

## Insurance Information

Name of Insured ______________________ Relationship to Patient ______________

Birthdate ______________ Social Security # ______________ Date Employed ______________

Name of Employer ______________________ Union or Local # ________ Work Phone ______________

Address of Employer ______________________ City ____________ State/Prov. ________ ZIP/Post. Code ________

Insurance Company ______________________ Group # ____________ Policy/ID # ______________

Ins. Co. Address ______________________ City ____________ State/Prov. ________ ZIP/Post. Code ________

How Much is your Deductible? ________ How Much Have You Used? ________ Max. Annual Benefit ________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured ______________________ Relationship to Patient ______________

Birthdate ______________ Social Security # ______________ Date Employed ______________

Name of Employer ______________________ Union or Local # ________ Work Phone ______________

Address of Employer ______________________ City ____________ State/Prov. ________ ZIP/Post. Code ________

Insurance Company ______________________ Group # ____________ Policy/ID # ______________

Ins. Co. Address ______________________ City ____________ State/Prov. ________ ZIP/Post. Code ________

How Much is your Deductible? ________ How Much Have You Used? ________ Max. Annual Benefit ________

Over Please

# Patient Medical History

Physician ______________________ Office Phone ______________________ Date of Last Exam ______________

| | Yes | No |
|---|---|---|
| 1. Are you under medical treatment now? | ☐ | ☐ |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? | ☐ | ☐ |

If yes, please explain ______________________

______________________

| | Yes | No |
|---|---|---|
| 3. Are you taking any medication(s) including non-prescription medicine? | ☐ | ☐ |

If yes, what medication(s) are you taking? ______________________

______________________

| | Yes | No |
|---|---|---|
| 4. Have you ever taken Phen-Fen/Redux? | ☐ | ☐ |
| 5. Do you use tobacco? | ☐ | ☐ |
| 6. Do you use controlled substances? | ☐ | ☐ |
| 7. Are you wearing contact lenses? | ☐ | ☐ |

9. Are you allergic to or have you had any reactions to the following?

| | Yes | No |
|---|---|---|
| Local Anesthetics (e.g. Novocain) | ☐ | ☐ |
| Penicillin or other Antibiotics | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Barbiturates | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Iodine | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Any Metals (e.g. nickel, mercury, etc.) | ☐ | ☐ |
| Latex Rubber | ☐ | ☐ |
| Other (please list) ______________ | ☐ | ☐ |

10. Women Only:

| | Yes | No |
|---|---|---|
| a) Are you pregnant or think you may be pregnant? | ☐ | ☐ |
| b) Are you nursing? | ☐ | ☐ |
| c) Are you taking oral contraceptives? | ☐ | ☐ |

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

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | ☐ | ☐ | Heart Disease | ☐ | ☐ | Chest Pains | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | Cardiac Pacemaker | ☐ | ☐ | Easily Winded | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Stroke | ☐ | ☐ |
| Swollen Ankles | ☐ | ☐ | Angina | ☐ | ☐ | Hay Fever / Allergies | ☐ | ☐ |
| Fainting / Seizures | ☐ | ☐ | Frequently Tired | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Asthma | ☐ | ☐ | Anemia | ☐ | ☐ | Radiation Therapy | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ | Emphysema | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Epilepsy / Convulsions | ☐ | ☐ | Cancer | ☐ | ☐ | Recent Weight Loss | ☐ | ☐ |
| Leukemia | ☐ | ☐ | Arthritis | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Joint Replacement or Implant | ☐ | ☐ | Heart Trouble | ☐ | ☐ |
| Kidney Diseases | ☐ | ☐ | Hepatitis / Jaundice | ☐ | ☐ | Respiratory Problems | ☐ | ☐ |
| AIDS or HIV Infection | ☐ | ☐ | Sexually Transmitted Disease | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ |
| Thyroid Problem | ☐ | ☐ | Stomach Troubles / Ulcers | ☐ | ☐ | Other ______________ | ☐ | ☐ |

# Patient Dental History

Name of Previous Dentist and Location ______________________ Date of Last Exam ______________

| | Yes | No |
|---|---|---|
| 1. Do your gums bleed while brushing or flossing? | ☐ | ☐ |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | ☐ | ☐ |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | ☐ | ☐ |
| 4. Do you feel pain to any of your teeth? | ☐ | ☐ |
| 5. Do you have any sores or lumps in or near your mouth? | ☐ | ☐ |
| 6. Have you had any head, neck or jaw injuries? | ☐ | ☐ |
| 7. Have you ever experienced any of the following problems in your jaw? | | |
| Clicking? | ☐ | ☐ |
| Pain (joint, ear, side of face)? | ☐ | ☐ |
| Difficulty in opening or closing? | ☐ | ☐ |
| Difficulty in chewing? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| 8. Do you have frequent headaches? | ☐ | ☐ |
| 9. Do you clench or grind your teeth? | ☐ | ☐ |
| 10. Do you bite your lips or cheeks frequently? | ☐ | ☐ |
| 11. Have you ever had any difficult extractions in the past? | ☐ | ☐ |
| 12. Have you ever had any prolonged bleeding following extractions? | ☐ | ☐ |
| 13. Have you had any orthodontic treatment? | ☐ | ☐ |
| 14. Do you wear dentures or partials? | ☐ | ☐ |
| If yes, date of placement ______________ | | |
| 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | ☐ | ☐ |
| 16. Do you like your smile? | ☐ | ☐ |

# Authorization and Release

*I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.*

X ______________________________________________

Signature of patient (or parent if minor)

Doctor's Comments ______________________________________________

______________________________________________

______________________ Signature ______________________ Date ______________

**_Diamond Dental, P.C._**
***K.H. George Lee, D.D.S.***
***Danny Salem, D.D.S.***

*10 Dunwoodie Street, Scarsdale, NY 10583*
*420 Lexington Avenue, Suite 228, NY, NY 1017*
*www.diamond-dental.com*
*914/472-9001 212/983-1701*

# FINANCIAL POLICY AND AGREEMENT

Please make your choice, sign below and return to receptionist. Payment Arrangements are requested before your visit. In an effort to provide you with quality Dental Care and flexible payment arrangements, we have expanded our payment policy. We will use our expertise to help you obtain the maximum benefits from your policy.

**FULL PAYMENTS ARE DUE IMMEDIATELY WHEN SERVICES ARE RENDERED.**

**We offer the following payment options:**

___ **Payment by CASH in Full**
___ **Payment by CHECK in Full**
___ **Automatic billing to your Visa or MasterCard**
___ **Dental Fee Plan Financing -** We will be happy to assist you with applying for financing should you so desire. We do not handle any financing “in house” but we do have financing available through Dental Fee Plan™.

• **INSURANCE:** We can file your insurance claims. You are responsible for any portion not covered by your insurance company. You must guarantee your insurance payments and co-payments with Visa/MasterCard, Cash or Checks.

• **CHARGES:** You will be charged for all insurance deductible, insurance co-payments, the remaining balance of charges not paid by insurance within 60 days, broken appointment fees and any outstanding balance on my (the guarantor’s) account which may include any dependents for all dental services rendered by Diamond Dental, P.C./K.H. George Lee, DDS/Danny Salem DDS & their staff. I understand there is a monthly interest of 1.5% of unpaid balance accrued on the account after 60 days once the service is rendered.

• **Broken Appointments:** We reserve the right to charge $20 per half hour for failed appointments which are cancelled without 24 hours prior notice. For long and special appointments (Two hours or longer), we need to be notified 48 hours prior.

Our office is a fully approved and accredited user of the Visa/MasterCard Health Care Incentive Program, which will enable you to use your Visa/MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

I assign my insurance benefits to the providers listed above. I understand that this form is a valid financial agreement. I certify that I have read and understand the above information.

______________________________ ______________________________ ___________________

Signature of Patient or Guarantor | Print Name | Today’s Date

## Authorized Healthcare Form & Credit Card Financial Agreement Contract
## Automatic Credit Card Charge Authorization

I, __________________ (name of Guarantor), authorize Diamond Dental, P.C. or K.H. George Lee, DDS or Danny Salem DDS (names of Providers) to keep my signature on file and to charge my MasterCard or Visa or American Express or Bank Debit Card account as indicated below for any outstanding balances on my and my dependent’s accounts.

I authorize payments of $_________ to be charged on the __first, __second, __third, __fourth week, and _____ of every month until all the remaining balance on my account is paid.

Patient Name: «FName» «MI» «LName» Date of Birth:

______________________________ ______________________________ ___________________

Signature of Card Holder | Print Card Holder/Guarantor’s Name | Today’s Date:

______________________________ _VS/MC/Other_________________ ___________________

Credit Card Number | Credit Card Type | Expiration Date

Credit Card Holder Billing Address:

Credit Card Imprint