Medical History

Patient Information

Patient _____ Date _____

Address _____

City _____ State _____ Zip _____

Email address _____

Patient SS# _____ Birth date _____

❑Male ❑Female ❑Single ❑Married ❑Widowed ❑Divorced

Occupation _____ Employer _____

Employer Address _____ Employer Phone _____

Spouse's Name _____

Spouse's Birth date _____ Spouse's SS# _____

Spouse's Occupation _____ Spouse's Employer _____

How did you learn about our practice?

❑ TV ❑ Newspaper ❑ Radio ❑ Google ❑ Website

❑ Mailings ❑ Other _____

❑ Family/Friend: Name _____

Dental Insurance

Subscriber's Name _____

Relationship to Patient _____

Insurance Co. _____ Group # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____ Relationship to Patient _____

Birth date _____ SS# _____

Insurance Co. _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurances submissions.

Responsible Party Signature _____

Relationship _____ Date _____

Phone Numbers

Home _____ Work _____ Ext. _____ Cell phone _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name _____ Relationship _____ Home Phone _____ Work Phone _____

Dental History

Bad Breath	Yes___ No___	Grinding teeth	Yes___ No___	Sensitivity to cold	Yes___ No___
Bleeding Gums	Yes___ No___	Gums swollen or tender	Yes___ No___	Sensitivity to heat	Yes___ No___
Blisters on lips or mouth	Yes___ No___	Jaw pain or tiredness	Yes___ No___	Sensitivity to sweets	Yes___ No___
Burning Sensation on tongue	Yes___ No___	Lip or cheek biting	Yes___ No___	Sensitivity when biting	Yes___ No___
Chew on one side of mouth	Yes___ No___	Loose teeth or broken fillings	Yes___ No___	Sores or growths in your mouth	Yes___ No___
Cigarette, pipe or cigar smoking	Yes___ No___	Mouth breathing	Yes___ No___	How often do you floss_____	
Clicking or popping jaw	Yes___ No___	Mouth pain, brushing	Yes___ No___	How often do you brush_____	
Dry Mouth	Yes___ No___	Orthodontic treatment	Yes___ No___	If there was a way to whiten or straighten	
Fingernail biting	Yes___ No___	Pain around ear	Yes___ No___	your teeth, would you like to hear more	
Food Collection between teeth	Yes__ No___	Periodontal treatment	Yes___ No___	information about it?	Yes___ No___

Reason for today's visit _____

Former Dentist _____ City/State _____ Date of last dental visit _____ Date of last dental x-rays _____

Please continue on back

Health History

Physician's Name and Address _____ Date of last visit _____

Former Dentist _____ City/State _____ Date of last dental visit _____ Date of last dental x-rays _____

PLEASE CHECK YES OR NO FOR EACH

AIDS	Yes___	No___	Fainting or dizziness	Yes___	No___	Respiratory Disease	Yes___	No___
Anemia	Yes___	No___	Glaucoma	Yes___	No___	Rheumatic Fever	Yes___	No___
Arthritis, Rheumatism	Yes___	No___	Headaches	Yes___	No___	Scarlet Fever	Yes___	No___
Artificial Heart Valves	Yes___	No___	Heart Murmur	Yes___	No___	Shortness of Breath	Yes___	No___
Artificial Joints	Yes___	No___	Heart Problems	Yes___	No___	Sinus Trouble	Yes___	No___
Asthma	Yes___	No___	Hepatitis	Yes___	No___	Skin Rash	Yes___	No___
Back Problems	Yes___	No___	Type_____			Special Diet	Yes___	No___
Bleeding abnormally,			Herpes	Yes___	No___	Stroke	Yes___	No___
with extractions or surgery	Yes___	No___	High Blood Pressure	Yes___	No___	Swelling of Feet or Ankles	Yes___	No___
Blood disease	Yes___	No___	HIV Positive	Yes___	No___	Swollen Neck Glands	Yes___	No___
Cancer	Yes___	No___	Jaundice	Yes___	No___	Thyroid Problems	Yes___	No___
Chemical Dependency	Yes___	No___	Jaw Pain	Yes___	No___	Tuberculosis	Yes___	No___
Chemotherapy	Yes___	No___	Kidney Disease	Yes___	No___	Tumor or growth on head		
Circulatory Problems	Yes___	No___	Liver Disease	Yes___	No___	or neck	Yes___	No___
Congenital Heart Lesions	Yes___	No___	Low Blood Pressure	Yes___	No___	Ulcer	Yes___	No___
Cortisone Treatments	Yes___	No___	Mitral Valve Prolapse	Yes___	No___	Venereal Disease	Yes___	No___
Cough, persistent or bloody	Yes___	No___	Nervous Problems	Yes___	No___	Weight Loss, unexplained	Yes___	No___
Diabetes	Yes___	No___	**Pacemaker/Defibrillator**	**Yes___**	**No___**			
Emphysema	Yes___	No___	**If yes, which side of the body**	**R___**	**L___**	Women:		
Do you wear contact lenses?	Yes___	No___	Psychiatric Care	Yes___	No___	Are you pregnant? Yes___	No___	Due Date_____
Epilepsy	Yes___	No___	Radiation Treatment	Yes___	No___	Are you nursing?	Yes___	No___

Additional Medical Information _____

Medications

List medications you are currently taking:

_____

_____

_____

_____

Pharmacy Name _____

Phone _____

Allergies

Aspirin	Yes___	No___
Barbiturates (Sleeping pills)	Yes___	No___
Codeine	Yes___	No___
Iodine	Yes___	No___
Latex	Yes___	No___
Local Anesthetic	Yes___	No___
Penicillin	Yes___	No___
Sulfa	Yes___	No___
Other	Yes___	No___

_____

_____

Have you had surgery within the last 5 years? _____

If yes—for what reason? _____

Were there any complications? _____

Have you ever been told that you need to be **premedicated** with antibiotics for dental work? _____

Patient Signature _____

Date _____

Four Ever Smile™
Replace Teeth Permanently

Four Ever Smile™ Implant Center
140 Adams Avenue, Suite C, Hauppauge, NY 11788
631-629-8075 / foureversmile.com
f: 631.886.1971 | e: info@foureversmile.com

New Patient Questionnaire

Our practice philosophy is to provide you with compassionate, expert care and comfort in a clean and calm environment, with all new high tech equipment. We believe that informed patients are better prepared to make decisions regarding their heath and well being. We encourage you to fill out these next few questions so we can help you with your interest and concerns about your dental needs and care.

How long are you hoping to keep your teeth?

What brought you into our office today?

Tell us a little about your teeth?

How important is prevention to you?

Would sedation interest you?

Are you 100% confident in your smile?

Any additional information that would be helpful for your treatment.

Signature of Patient/Legal Guardian _____ Date _____ Print Patient Name _____

Witness _____ Doctor _____

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HIPAA
Consent Form

Four Ever Smile™ and staff (collectively labeled Dentist) agree to maintain privacy of our patients as outlined in this HIPAA form. The Dentist takes pride in being able to extend a greater degree of privacy than is required by HIPAA, state confidentiality mandates, and common law.

Federal and State Privacy laws are complex. Unfortunately, some dental offices try to find loopholes around these laws. For example, HIPAA forbids dentists from receiving money for selling lists of patients or protected health information to companies to market their products or services directly to patients without authorization. Some dental practices, though, can lawfully circumvent this limitation by having a third party perform marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Dentist believes this is improper and may not be in the patient's best interest. Accordingly, Dentist agrees not to provide any list for marketing or be paid for selling patients lists or protected health information to any party for the purpose of marketing directly to patients. Regardless of legal privacy loopholes, Dentist will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

In consideration for treatment and the above noted patient protection, Patient agrees to refrain from directly or indirectly publishing or airing commentary upon Dentist and his practice, expertise and/or treatment unless explicitly mandated by law. Publishing is intended to include attribution by name, by pseudonym, anonymously. Dentist has invested significant financial and marketing resources in developing the practice. In addition, Patient will not denigrate, defame, disparage, or cast aspersions upon the dentist, and (ii) will use all reasonable efforts to prevent any member of their immediate family or acquaintance from engaging in any such activity. Published comments on web pages, social media, blogs, and/or mass correspondence, however well intended, could severely damage Dentist's practice.

Dentist feels strongly about Patient's privacy as well as the practices right to control its public image and privacy. Both Dentist and Patient will work to prevent publishing or airing of commentary about the other party from being accessed via Internet, blogs, or other electronic, print, or broadcast media without prior written consent. Finally, this agreement shall be in force and enforceable (and fully survive) for a period of the longer of (a) five years from Dentist's last date of service to Patient; or (b) three years beyond termination of the Dentist-Patient relationship. As a matter of office policy, Dentist is requiring all patients in its practice sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Dentist's patients.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations. We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Signature of Patient/Legal Guardian _____ Date _____ Print Patient Name _____

Witness _____ Doctor _____

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4 Stored Patient Information Consent Form

I grant my permission to Four Ever Smile™ to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured website for Pure Dental. I understand that, for security purposes, the site requires user ID and password for access and use. I also understand that Pure Dental and I are responsible for maintaining the strict confidentiality of any 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 as a result of my failure to maintain confidentiality. I understand that Pure Dental 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 Pure Dental web site with my ID or password. I also agree to immediately notify Pure Dental of any unauthorized use of my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose with respect to patient confidentiality that limit the availability to make use of certain services or to transmit certain information to third parties. I understand that Pure Dental will represent and warrant that they will, at all times during the terms of this agreement and thereafter, comply with the laws directly or indirectly applicable that may now 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 such laws. I agree that Pure Dental has the right to monitor, retrieve, store, upload and use my information with operation of such services, and is acting on my behalf in uploading my patient information. I understand that Pure Dental will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand that Pure Dental cannot and does not assume any responsibility for my use or misuse of patient information or other information transmitted, monitored, stored, uploaded to the website on my behalf. I understand that Pure Dental 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 the services.

____I have read the information above regarding the secured uploading of patient information to the website for the dental practice, and grant Pure Dental permission to securely upload information to the website.

Signature of Patient/Legal Guardian _____ Date _____ Print Patient Name _____

Witness _____ Doctor _____

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Financial Agreement
Consent Form

Thank you for choosing Four Ever Smile™ as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

Full Payment Is Due At Time of Service.
We Accept Cash, Checks and All Major Credit Cards.
We Also Offer Interest Free Financing

If you are covered by insurance we may accept assignments of benefits as full or partial payment. However, we do require that all deductibles and co-pays be paid at the time of service. If there is a balance due on your account after insurance payments are received, the remaining balance is your responsibility. Your insurance is a contract between you and the insurance company. We are not a party to that contract. In the event we do not accept assignments of benefits or the insurance company does pay what is estimated, as their portion of payment, then the balance becomes your responsibility as the patient. If your insurance has not paid your account in full in 90 days of treatment, the balance will be automatically rolled over to your private balance and you will be responsible for payment. Please be aware that your insurance company may consider some, if not all, of the services provided either a non-covered service or not considered reasonable or necessary. Some insurance companies will give alternate benefits for certain procedures and pay lesser amounts for the services rendered. We are not responsible for the decisions of your insurance company. We will perform, with your concurrence, whatever dental services we feel is in your best interest.

If you have an insurance company where we are a participating provider all co-pays and deductibles are due at the time of treatment. We are not responsible for the insurance company's arbitrary determination of alternate benefit or treatment that they consider an uncovered service. We require that all adults accompanying a minor stay throughout the duration of treatment. Any adult accompanying a minor will be responsible for full payment.

Unless canceled, at least 48 hours in advance, our policy is to charge for a missed appointment. It is not fair to our other patients or providers if you do not give notice that you cannot make your appointment. 48 hours gives us enough time to fill that time slot for a patient that might be waiting for an earlier appointment. We charge a minimum of $75 per missed appointment.

Thank you for understanding our financial policy. I have read the financial policy, understand and agree to the terms. I understand that any unpaid fees by my insurance company, if any, are my sole responsibility.

Signature of Patient/Legal Guardian _____ Date _____ Print Patient Name _____

Witness _____ Doctor _____

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