Patient Information

Patient Name: _____ Date: _____
Last First MI

Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____ Email: _____

Phone Home: _____ Work: _____ Ext: _____ Cell: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Last Dental Visit Date: _____ Name of Prior Dentist: _____ Reason for this visit: _____

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

☐ AIDS
☐ Allergies _____ _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints/Implants
☐ 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:
☐ _____
☐ _____

- Do you use tobacco products? ☐ Yes ☐ No If yes, what type & how often? _____
- Have you been advised by a health care professional that you need antibiotics before dental treatment? ☐ Yes ☐ No
- 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: _____
- Please list all prescription and over the counter medications which you are currently taking: _____

_____

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: _____ Drivers License State & #: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

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

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 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. 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 at home or at my work 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

HEIGHTS DENTAL SMILES
HAPPY SMILES HEALTHY LIVES

Susanna N. Zilberman, D.D.S., P.C.

OUR FINANCIAL POLICY

Thank you for choosing our practice as your healthcare provider. Our office is dedicated to providing optimal care for every patient in the most economical way possible. The following is a statement of our financial policy. Please read it and let us know if you have any questions. We feel misunderstandings can be avoided when complete information is exchanged.

OPTIONS FOR PAYMENT OF TREATMENT:

1. **Non-Insurance Patients**: Payments is expected at the time of service for treatment performed that day unless prior arrangements have been made. For your convenience, we accept cash, personal checks, money orders, and all major credit cards.

2. **Insurance Patients**:

- We will file an insurance claim on your behalf as a courtesy to you; however, you must supply, prior to treatment, all the necessary information for filing.
- Any deductible as well as any estimated percentages your insurance does not cover, are to be paid on the date of treatment.
- It is the patient's responsibility to know the details of the insurance coverage, including percentages payable, waiting periods, deductibles, yearly maximums, services not covered under the plan, and any other related information.
- If your insurance company has not paid their liability in full within 60 days, the balance then becomes, the patient's liability.
- For patients whose insurance company pays them directly, payment is expected on the date of treatment
- Your insurance policy is a contract between you and your insurance company and the financial responsibility for your treatment is yours whether the insurance company pays or not.

3. Finance charges of 1.5% per month will be applied to balances over 60 days old.

4. Long term payments may be available. We have information on several companies that offer this service and we can help you with details.

Each time a patient misses an appointment without providing proper notice (at least 24 hrs), another patient is prevented from receiving care. Therefore, Heights Dental Smiles reserves the right to charge a fee of $50.00 for all missed appointments.

I HAVE READ THIS FINANCIAL POLICY AND UNDERSTAND AND AGREE TO THE TERMS OF THIS POLICY.

Patient Signature:_____ (SEAL) DATE:_____

I allow for release of my x-rays and records to my insurance company as needed for proper processing and payment of my dental claims. I allow for release of my x-rays and records to other dental specialists, as needed, for my dental care. I also allow for photograph to be taken of my mouth and dental work as a record of progress of my treatment.

Patient Signature:_____(SEAL) DATE:_____ _

HEIGHTS DENTAL SMILES
HAPPY SMILES HEALTHY LIVES

Susanna N. Zilberman, D.D.S., P.C.

By signing below I acknowledge that I have received or reviewed the Notice of Privacy. I agree with the terms of this notice and understand my rights under this notice. **By signing below I consent for the use of my personal health information for treatment, payment, and operations and other uses as described in the privacy notice.** I also understand that I have the rights not sign this agreement.

Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

If we are unable to get your acknowledgement then our office will make a notation as to the reason why it was not obtained.

Reason why acknowledgement was not obtained:

_____

_____

_____

Staff Name: _____

Signature: _____

Date: _____

Heights Dental Smiles
Susanna N. Zilberman, D.D.S.

PATIENT INFORMATION RELEASE CONSENT

List the family members or others, if any, relationship, and contact numbers, with whom we may discuss your general dental conditions and diagnosis:

_____

_____

List the family members or others, if any, relationship, and contact numbers, whom we may contact in case of an emergency:

_____

_____

List the family members or others, if any, relationship, and contact numbers, with whom we may discuss your billing information, including account balance:

_____

_____

List Pharmacy name and contact number where we may call in and discuss prescriptions and medication intra-actions with pharmacist:

_____

You may leave messages (i.e. appointment reminders):

With others at my home:	Yes	No
On my answering machine at home:	Yes	No
With others at my work:	Yes	No
On my voice mail at work:	Yes	No
On my cell phone:	Yes	No

I authorize the use of x-rays, study models, photographs and/or videotapes of my case for presentations and publications of the doctor.

Signature of Patient/Guardian _____

Please print name _____ Date_____