Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

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

E-Mail Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

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

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV+
- ☐ 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:

- ☐ _____
- ☐ _____

- 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: _____
- Are you currently taking any medications? ☐ Yes ☐ No
  If yes, please list: _____
- Do you currently take a daily multivitamin? ☐ Yes ☐ No
  If yes, please specify: _____

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: _____

Responsible Party for Payment Information (if you then just put self)

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

*****PATIENT MUST FILL OUT THIS SECTION.*****

In Case Of Emergency Contact

Name_____ Address _____

Phone _____ Relationship to patient_____

Consent for Services

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. 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.

I agree to the use of anesthetics, sedatives and other medication as necessary. I full understand that using anesthetic agents embodies certain risks. I understand that I can ask complete recital of any possible complications.

I give consent to the doctor's or staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash 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 any co-payment of all dental services not covered by the insurance. 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.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

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, or within five (5) days of billing if credit shall be extended. 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

Central Park Dental Aesthetics

HIPAA Patient Consent Form

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare provides who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party players
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I have been informed by you and your "Notice of Privacy Practices", containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such "Notice of Privacy Practices" prior to signing this consent. I understand that his organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time to obtain a current copy.

I understand that I may request in writing that you restrict my private information. Also that it is used or disclosed to carry our treatment, payment, or healthcare options. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time.

Patient name: _____

Signature: _____ Date: _____
(Parent/Guardian if under 18)

Dr. Tammy Chen, D.D.S.
Central Park Dental Aesthetics
25 West 54th Street
Suite 1F
New York, NY 10019
P: 917.831.4344
F: 917.831.4345

To all patients of our office:

We appreciate and respect the trust you place in us to provide you with optimum dental care and services.

Please understand that your benefit place is an arrangement that involves you, your insurance carrier and your employer. Occasionally, services that are rendered are not covered by your plan or there is a deductible or co-payment that you or we are not aware of at the time of the visit.

In order for our office to run smoothly and continue to offer you high quality care, we respectfully request that you sign below to authorize our office to keep your signature and credit card on file for any balances that are not covered by your insurance or a balance that is due to a cancellation. (as per our cancellation policy.

Thank you for your cooperation,

Dr. Tammy Chen and Staff

_____

Name: _____

Name on credit card:_____

Card Type: (please circle one)

Visa MasterCard Discover

Card Number: _____ **Exp. Date:** _____

Security Code: _____

Signature: _____ **Date:**_____

Central Park Dental Aesthetics

25 West 54th Street
Suite 1F
New York, NY 10019
P: 917.831.4344

Payment Procedures for 30 days after Treatment
Or
Receipt of insurance Benefit Payment

I've been made fully aware that this is only an estimate and my insurance company may pay more or less than the estimated amount. I am paying the *estimated* co-payment with the understanding that I am still responsible for whatever balance remains after the insurance payment is received. If the actual insurance payment is more than the estimated amount, I will receive a refund of the difference. If the actual insurance payment is less than the estimated amount, I will be notified by mail, telephone, and email of the remaining balance due. I agree to pay that remaining balance in full within 30 days. If for any reason I cannot make scheduled payments, the patient must immediately contact Central Park Dental Aesthetics to make acceptable arrangements. Central Park Dental Aesthetics reserves the right to refer all unpaid accounts to collection agencies. Any fees associated with collection, including collection agency contingency fees, attorney's fees, and/or court costs, will be added to the patient's account balance, in addition to a 10% interest fee. After accounts are placed with collection agencies, all patient visits and procedures will be on a cash only basis.

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for services and materials not paid by my dental or health benefit plan. To the extent permitted by law, I consent to your use and disclosure of my personal health information to be used for the sole purpose of collecting any amounts due to the practice.

Patient or Guarantor Signature: _____

Print: _____ Date: _____

Central Park Dental Aesthetics

"Patient Attendance Policy Agreement"

Through the years, our office strived to provide each patient with the highest quality of care while attempting to accommodate your schedule and ours. In order to do this, we provide reserved times for each patient in order to minimize waiting times and assure quality treatment.

Cancellations, especially last minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of our other patients. We ask for your full cooperation with our policy as follows:

- **IF YOU ARE UNABLE TO KEEP A SCHEDULED APPOINTMENT, PLEASE NOTIFY US 24 HOURS IN ADVANCE. ON WHITENING AND SPECIALIST APPOINTMENTS, 48 HOURS NOTICE IS REQUIRED. (CANCELLATION FEE WILL DEFINITELY APPLY TO SPECIALIST AND WHITENING VISITS, NO EXCEPTIONS)**
- **ALL CANCELLATIONS THAT OCCUR WITHIN 24 HOURS AND NO-SHOWS WILL BE DOCUMENTED IN OUR RECORDS, WITH A $75 CHARGE FOR HYGIENE APPOINTMENTS, A $100 FEE FOR DOCTORS APPOINTMENTS, AND $150 FOR A SPECIALIST APPOINTMENT OR WHITENING APPOINTMENT.**
- **IF YOU ACCUMULATE 3 CANCELLATIONS OR NO-SHOWS, WE WILL BE UNABLE TO PROVIDE YOU WITH FURTHER SERVICES AT OUR OFFICE.**

We believe this policy is necessary for the benefit of all our patients, and allows us to provide the highest quality of treatment for everyone.

Thank you for your cooperation!

Patient Signature: _____

Name (Printed): _____

Date: _____