SMILE BY DESIGN

Dr. Lionel Abitbol, DDS
1603 McDonald Ave Brooklyn, NY 11230
info@smilebydesigndental.com

PATIENT INFORMATION

Date: ☐ New Patient ☐ Update

Patient:

Last | First | MI | Preferred | Title

☐ Male ☐ Female ☐ Child* ☐ Student** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

*If Child, provide parent/guardian name(s) below:

Parent/Guardian Name(s)

**If Student, please complete: ☐ Full-time ☐ Part-Time

School/Location

Patient Date of Birth: Patient SSN:

Address:

Address Line 1

Address Line 2

City ST ZIP Code

E-Mail:

Home:
Cell:
Other:
Pager:
Fax:

Referral? ☐ Yes ☐ No ***Whom may we thank for referring you?:***

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

Name Relationship Tel:

EMPLOYMENT INFORMATION

Employer: Occupation:

Address:

Address Line 1

Address Line 2

City ST ZIP Code

E-Mail:

Work: Ext:
Direct:
Other:
Pager:
Fax:

INSURANCE INFORMATION

Subscriber:

Last | First | MI | Preferred | Title

Subscriber Date of Birth: Subscriber SSN:

Subscriber Employer:

Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Primary Insurance Carrier:

Group/Policy No.: ID No.:

Address:

City ST ZIP Code

Tel:
Toll-free:
Fax:

Secondary Insurance Carrier:

Group/Policy No.: ID No.:

Address:

City ST ZIP Code

Tel:
Toll-free:
Fax:

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DENTAL HISTORY

ORAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Date of Last Dental Visit: _____ Treatment Type: _____

☐Y☐N Are you currently having dental discomfort? If yes, explain: _____
☐Y☐N Any unhappy/unpleasant dental experiences? If yes, explain: _____
☐Y☐N Any injuries to mouth/teeth/head? If yes, explain: _____
☐Y☐N Any missing teeth other than wisdom teeth or orthodontic extractions?
☐Y☐N Loose teeth or broken fillings?
☐Y☐N Orthodontic (braces) appliances now or in the past?
☐Y☐N Gums bleed when brushing or flossing?
☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N
☐Y☐N Any concerns about the appearance of your teeth?
☐Y☐N Does it hurt to bite or chew?
☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N
☐Y☐N Do you have TMJ pain, clicking or popping of the jaw?
☐Y☐N Food collection between the teeth?
☐Y☐N Does any type of dental treatment make you nervous? If yes, please explain below:

_____

How often do you floss?

☐Never ☐Seldom ☐About Half the Time ☐Everyday

How often do you brush?

_____

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

☐Y☐N Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)

_____

☐Y☐N Any unusual speech habits? If yes, explain: _____
☐Y☐N Any lost teeth?
☐Y☐N Does the patient receive assistance with brushing and flossing? If yes, how often?

_____

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MEDICAL HISTORY

General Health: ☐Excellent ☐Good ☐Fair ☐Poor

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years? .....
☐Y☐N Any serious illnesses/surgeries? .....
☐Y☐N Use tobacco in any form? If Yes, Type: .....
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

Female Patients: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: .....

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

.....

Do you have, or have you ever had any of the following? (Check all that apply): ☐ None

☐Acid Reflux	☐Bulimia	☐Hearing Problems	☐Psychiatric Treatment
☐ADHD	☐Cancer/Malignancy	☐Heart Attack	☐Radiation/Chemo
☐AIDS/HIV	☐Cerebral Palsy	☐Heart Disease	☐Respiratory Disease
☐Anemia	☐Chemical Dependency	☐Heart Murmur	☐Rheumatic Fever
☐Anorexia	☐Chicken Pox	☐Hepatitis	☐Sinus Problems
☐Anxiety	☐Convulsions	☐High Blood Pressure	☐Stroke
☐Artificial Heart Valve	☐Depression	☐Kidney Disease	☐Thyroid Condition
☐Artificial Joints	☐Diabetes	☐Liver Problems	☐Tuberculosis
☐Arthritis	☐Dizziness/Fainting	☐Mitral Valve Prolapse	☐Ulcers
☐Asthma	☐Epilepsy/Seizures	☐Mononucleosis	☐Venereal Disease
☐Autism/Asperger's	☐Frequent Ear Infections	☐Pacemaker	
☐Bleeding Disorder	☐ Frequent Headaches	☐Other – please list:	

Are you <u>ALLERGIC</u> to or have you ever had any reaction to the following? (Check all that apply): ☐ None

☐Aspirin	☐Codeine	☐Lactose Intolerance	☐Sleeping Pills
☐Anesthetic – Local	☐Dairy	☐Metal Sensitivity	☐Sulfa Drugs
☐Barbiturates	☐Latex	☐Nitrous Oxide Sedation	☐Penicillin/Other Antibiotics
☐Other – please list:			

MEDICATION INFORMATION

Are you currently taking any of the following? (Check all that apply): ☐None

☐Antibiotics/Sulfa Drugs	☐Antihistamines/Allergy	☐Daily Aspirin	☐Blood Pressure Medications
☐Blood Thinners	☐Cancer/Chemo Medications	☐Cortisone/Steroids	☐Heart Medication/Digitalis
☐Insulin	☐Nitroglycerin	☐Oral Contraceptives	☐Osteoporosis Medications
☐Other Diabetic Medications	☐Recreational Drugs	☐Thyroid Medications	☐Tranquilizers
☐Other (please list below)			

Drug Name	Dosage	Reason Prescribed

PHARMACY INFORMATION

Pharmacy Name:
Pharmacy Phone #:

By signing below, I certify that the information above is accurate and complete to the best of my knowledge.

Signature: X_____ Date: _____

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FINANCIAL GUIDELINES

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major dental insurance payments, however we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.

- **Workers Compensation claims** will be filed for you. Please understand the carrier will assign a dollar amount that will be paid towards the claim, which may or may not cover the entire fee. Any amount not covered by the carrier, will be your responsibility.

- **Minors must be accompanied by a parent or legal guardian**. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - unless prior financial arrangements have been made.

- **Payment Information:**
  - All major credit cards are accepted (Visa, MasterCard, Discover)
  - Various financing options with Wells Fargo or CareCredit® by Synchrony Bank

Short Cancelled/ Missed Appointments

- **Please give 48 hours notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.
  Short canceled or missed appointments fee of $75 for the time allotted for your appointment.

By signing below I acknowledge I have read and understand the guidelines above.

Signature: X_____ Date: _____

PATIENT CONSENT- PAYMENT AUTHORIZATION

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize payment directly to *Smile By Design* of the dental benefits otherwise payable to me.

I hereby authorize *Smile By Design* to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature: X_____ Date: _____

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HIPPA / NOTICE OF PRIVACY PRACTICES : CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Smile By Design Dentistry, P.C.
1603 McDonald Ave
Brooklyn, NY 11230
718.265.6699

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out **treatment, payment activities and heath care operations**.

Signature: X_____ **Date:** _____

If this Consent is signed by a parent or legal guardian on behalf of the patient, please complete the following:

Parent or Guardian Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.