Park Avenue Dental Group
Personalized & Comfortable

New Patient Forms
Welcome to Our Practice

Patient First Name: _____ Last:_____ MI____

Date of Birth:_____ Gender: ___Male ___ Female SSN:_____

Title:_____ Family Status: ___ Married ___ Single ___ Child ___ Other Prev. visit_____

Email:_____ Best time to call: _____

Contact Information: _____Home _____ Mobile _____Work

Preferred Contact Method: (In the event that we need to urgently speak with you or the best way to reach you) Please circle the following: Home Work Mobile E-mail Text Message

Address: _____ Apt: _____

City:_____ State: _____ Zip code: _____

Emergency Contact

Name:_____ Relation: _____ Phone:_____

How did you hear about us?

_____

Primary Dental Insurance

Name of Insurance :_____ Phone:_____

Name of Insured's :_____ Insured's DOB: _____

Relation to Insured:_____ ID #:_____ Group #:_____

Insured's Address:_____ Apt:_____

City:_____ State:_____ Zip Code:_____

Insured's Employer:_____ Phone:_____

Employer Address: _____

City:_____ State: _____ Zip Code: _____

Secondary Dental Insurance

Name of Insurance :_____ Phone:_____

Name of Insured's :_____ Insured's DOB: _____

Relation to Insured:_____ ID #:_____ Group #:_____

Insured's Address:_____ Apt:_____

City:_____ State:_____ Zip Code:_____

Insured's Employer:_____ Phone:_____

Employer Address: _____

City:_____ State: _____ Zip Code: _____

Medical Insurance

Name of Insurance :_____ Phone:_____

Name of Insured's :_____ Insured's DOB: _____

Relation to Insured:_____ ID #:_____ Group #:_____

Medical History

Please indicate by **circling** which of the following conditions you've had or currently have:

Heart Disease/Surgery	Heart Murmur or Defect	Irregular Heartbeat
Angina/Chest Pain	Heart Attack/Failure	Congenital Heart Disorder
Mitral Valve Prolapse	Scarlet Fever	Rheumatic Fever
Shortness of Breath	Frequent Cough	Sinus Trouble
Asthma	Tuberculosis	Cancer
Radiation Treatment	Chemotherapy	Osteoporosis
Bisphosphonates	Osteonecrosis of Jaw	GI Disease
Ulcers	Recent Weight Loss	Artificial Heart Valve
Heart Pacemaker	Pulmonary Shunt	High Blood Pressure
Low Blood Pressure	Bacterial Endocarditis	Unexplained Fever
Bruise Easily	Anemia	Frequent Diarrhea
Diabetes	Excessive Thirst	Hypoglycemia
Liver Disease	Hepatitis A (infectious)	Hepatitis B or C
Kidney Problems	Renal Dialysis	Thyroid Disease
Parathyroid Disease	Arthritis/Gout	Rheumatism
Pain in Jaw Joints	Artificial Joint	STD/HIV/AIDS
Coronary Stent	Excessive Bleeding	Blood Transfusion
Sickle Cell Disease	Hemophilia	Methemoglobinemia
Leukemia	Blood Transfusion	Swelling of Limbs
Lung Disease	Cold Sores/Herpes	Stroke

Epilepsy or Seizures	Fainting or Dizziness	Glaucoma
Tumors or Growth	Psychiatric Care	Alzheimer's Disease
Allergies (Medicines)	Allergies (Pollen/Dust)	Hives or Rash
Need Premedication?	Ever taken fen-phen?	

Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? If yes please list them

_____

_____

_____

Are you allergic to any medications or substances?

_____

_____

Women (Please check) Pregnant: Yes No **Trying to get pregnant:** Yes No

Pacemaker : Yes No **Pre-medication:** Yes No

Smile Evaluation

1) Do you like the appearance of your teeth and your smile? Yes No

If no, explain: _____

2) Are your teeth all in alignment (straight)? Yes No

If not, explain: _____

3) Do you have spaces that you don't like? Yes No

If yes, explain: _____

4) Do you like the color of your teeth? Yes No

If not, explain: _____

5) Do you like the shape of your teeth? Yes No

If not, explain: _____

6) Are your teeth: Chipped, Too Forward, Hidden? Yes No

If yes, explain: _____

7) Are your teeth wearing on the biting surfaces? Yes No

If yes, explain: _____

8) Are there old silver fillings or dental work you don't like to look at? Yes No

If yes, explain: _____

Cancellation Policy

Office hours are by appointment and we do value your time. Because of the level of service we provide our patients, your appointment is especially held just for you, so that we have the right amount of time for your procedure at our office. When you make an appointment, please be sure that you will be able to keep it. If you cannot make an appointment as scheduled, please notify the office 48 hours BEFORE your appointment time or as soon as possible. Cancellations must be made during normal office hours or over the phone by speaking directly to one of our dental professionals. There will be a charge of $50 for any appointments cancelled with less than 48 hours' notice for your appointment.

Please know that we understand that emergencies and unforeseen patient treatment problems may arise, causing schedule changes on both your end and ours. That being said the office will be flexible in accommodating any unforeseen events that might arise in your schedule; however we expect you to respect our time as we respect yours and constant last minute cancellations and or no shows will be penalized with a fee.

Patient Signature: _____

Patient Name: _____

Date: _____

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your provider if you do not understand this authorization and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except; (a) to extent information has already been shared based on this authorization, you must submit your request in writing to provide at the following address (insert address of provider):

3. You may refuse to sign this authorization. Your refusal to sign will not affect to obtain treatment, payment, enrollment or eligibility for benefits. However, you may be required to complete this authorization from before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceeding, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access, or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. **Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical test, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for medical provider to release

"Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosure: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purpose; (g) to correctional institutions or law enforcement officials for certain purpose regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporally suspended on their written representation that an accounting would likely impede their activities.

Consent for Photography

Waiver and Consent

I, _____ the undersigned, do hereby authorize and consent to the use of certain photographs/ x-rays of me taken by Park Ave Dental Group.

I hereby grant them permission to reproduce, publish, print, use and distribute copies of such photographs/ x-rays either in an official medical publication or in the form of prints, slides or film for use in connection with articles and lectures dealing with jaw or dental disorders as well as social media. I specifically waive any claims for invasion of my personal privacy, which might accrue to me on account of the use of such pictures without my express consent in each instance.

NO FULL-FACE OR IDENTIFYING PHOTOS WILL BE USED WITHOUT YOUR EXPRESSED WRITTEN CONSENT FOR EACH ONE.

Polaroid photographs taken during treatment are used by our laboratories for cosmetic purposes for the fabrication of your crown, bridge or denture and are a part of your permanent dental records.

_____
Patient's Signature and/or Guardian

_____
Date

Please initial one of the following:

_____ I do not consent to the use of slides or photography for use in dental education or publications

_____ I do consent to the use of slides or photography for use in dental education or publications.

_____ I do consent to the use of slides or photography EXCEPT full face or identifying views.