Patient's Initials: _____

Welcome

STONY BROOK GENERAL & COSMETIC DENTISTRY
Smile For A Lifetime

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, we will be happy to help.

PATIENT INFORMATION

_____ _____
(Last Name) (First Name) (MI) (I prefer to be called)

❒ Male ❒ Female ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

DOB _____ SS# _____ Driver Lic# _____
(MM/DD/YYYY)

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Ext. Cell: _____

Email Address: _____

(If you are married, please fill out Spouse Info, If a Child, RP Info)

❒ Spouse ❒ Responsible Party (MARK APPROPRIATE RESPONSE)

_____ _____
(Last Name) (First Name) (MI) (I prefer to be called)

DOB _____ SS# _____ Driver Lic# _____
(MM/DD/YYYY)

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Ext. _____ Cell: _____

Email Address: _____

DENTAL INSURANCE INFORMATION

Insurance Co. Name: _____ Phone# _____

Group Policy#: _____ Insured's Name: _____

Insured's DOB: _____ Subscriber ID#: _____ SS#: _____

Insured's Employer: _____

REFERRAL INFORMATION

(If you have been referred by one of our patient then please provide patient's name for monthly referral raffle – please contact front desk for more details)

- **Whom we may thank for referring you?** ❒ Newspaper ❒ Website/Internet
❒ Patient _____ Patient's Contact# _____

EMERGENCY CONTACT INFORMATION

Name(Outside Of Household): _____ Ph# _____

Patient's Initials: _____

DENTAL HEALTH QUESTIONNAIRE

Please help us better understand your dental health needs and goals by answering the following questions. (check the best answer)

1. Have you had a full mouth set of X-rays (other that routine cavity detecting x-rays) within the last 3 years? ❒Yes ❒ No

2. I have a ❒ Low ❒ Moderate ❒ high fear of going to the dentist.

3. My mouth and teeth are ❒ very ❒ moderately ❒ not (comfortable.)

4. I am very ❒satisfied ❒dissatisfied with the appearance of my teeth.

5. I think my present state of dental health is ❒ excellent ❒ good ❒ fair ❒ poor.

6. Are you concerned about the following (Please check box): ❒ Whitening your teeth

❒ Replacing old mercury silver fillings ❒ Appearance of my smile ❒ Recurring or untreated gum disease ❒ Current pain ❒ Prevention of decay ❒ Mouth odor ❒ Other _____

7. I am interested in knowing about: (Please check box): ❒ Dentures ❒ Braces (Orthodontics) ❒ Cosmetic Dentistry ❒ Implants ❒ Sleep Dentistry ❒ Improving my chewing function or smile

8. SMOKING: ❒Yes ❒ No (If yes, How Many / day: _____ How long? _____ mo/yrs)

MEDICAL HEALTH INFORMATION

1. Do you have a health problem? ( ) YES ( ) NO If yes, what? _____

2. Name of your medical physician?_____ Phone _____

When was your last complete physical exam? _____

3. Are you under the care of a physician? ( ) YES ( ) NO If yes, since when and why? _____

4. Are you currently taking any medication? ( ) YES ( ) NO What? _____

5. Are you allergic to penicillin, antibiotics or other drugs? ( ) YES ( ) NO What? _____

6. Do you have other allergies? ( ) YES ( ) NO What? _____

7. Have you ever had a serious illness/major surgery? ( ) YES ( ) NO

When? _____ What? _____

Please check from following that applies to your health condition:

❒ arthritis	❒ heart trouble	❒ pregnancy
❒ anemia	❒ hepatitis	❒ psychiatric treatment
❒ artificial joints	❒ high blood pressure	❒ radiation treatment
❒ asthma	❒ HIV or AIDS positive	❒ rheumatic fever
❒ cancer	❒ infections	❒ stomach problems
❒ diabetes	❒ kidney problems	❒ TB
❒ epilepsy or seizure disorders	❒ latex allergies	❒ venereal diseases
❒ nervous disorders	❒ liver problems	❒ Other _____
❒ fainting or dizziness	❒ low blood pressure	_____
❒ hearing loss	❒ thyroid condition	_____

9. Any other diseases, conditions, or problems not listed? _____

10. Would you like to speak to the Doctor privately about any problem? _____

Patient's Initials: _____

Financial Agreement/Receipt of HIPAA Privacy Notice/Consent for Treatment

We, at Stony Brook General and Cosmetic Dentistry (SBGCD), find that open communication with our patients regarding our financial policy assists us in providing the best possible service to you. Please take the time to read these policies concerning dental insurance benefits. If you have questions, please feel free to ask.

Dental insurance is intended to only be an aid and rarely covers 100% of the total cost of your dental care. Every plan has its own provisions, which we must abide by. Certain costs will be passed along to the patient, such as deductibles, co-payments and co-insurance amounts. As a patient, you have certain responsibilities: (1) to pay amounts not covered by your insurance carrier (2) to be knowledgeable about your plan's covered and non-covered services (3) to notify the office if there are any changes in your coverage. We will do our best to work within your plan to help you receive maximum benefits. Please be advised that responsibility for full payment is solely yours, whether or not you have insurance. If it becomes necessary to send your account to a collection agency or attorney, you will be responsible for all costs, interest, and attorney fees. There is a $25.00 fee for all checks returned for insufficient funds. SBGCD reserves the right for all future payments by the undersigned to be paid in cash or money order. For all patient balances over 30 days, there is a $5.00 statement processing fee, cumulative per month, on unpaid monies due to the practice.

Appointment Cancellation / No-Show Policy

We value your time so you can expect us to see you at the appointed time and to keep you time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, **please provide us at least 1 working day advanced notification so that we may use our time to accommodate other patients**. Broken and missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours. **SBGCD reserves the right to charge $50.00 no-show/cancellation fee for any office related visits and procedures.**

Payment Options / Finance Charges and Fees

For your convenience we accept Cash, Check, Visa, MasterCard, AMEX and Discover. We also offer short and long-term financing options (interest free options may apply). Balances in excess of 30 days are subject to a finance charge of 1.5% per month (18% annual). Returned checks are subject to a $15.00 accounting fee.

Managed Care Plans & All Other Insurances

We participate with a full range of insurance plans in order to offer flexibility to our patients. Our dental providers strictly follow the regulations and guidelines of these plans. On the date of service, we are contractually obligated to collect any appropriate co-payments, co-insurance and deductibles from you, the patient, as per our agreement with the carriers.

Patients who are covered by more than one dental insurance carrier should notify the receptionist at the time of registration. It is your responsibility to know the limitations of your supplemental/secondary policy. If you have two insurance policies, the co-payment of the primary insurance is collected at the time of service.

Acknowledgement As Signer On The Account

Upon my signature below, I attest that I have read and understand all the provisions discussed herein. Any questions I have asked have been answered to my satisfaction and to the extent where I can place my signature on this document. I understand my rights and obligations as a patient of SBGCD. Should the patient be a legal minor as defined in the State of NY Statute, I hereby attest as the signer below, that I am the lawful guardian of the minor.

Patient's Initials: _____

All Patients Must Read and Sign the Following Before Treatment Can Commence

ASSIGNMENT AND AUTHORIZATION

Assignment of Insurance Benefits

I authorize that my insurance benefits be paid directly to SBGCD. I acknowledge that I am responsible for full payments of services rendered. I have read the above information carefully, and agree with all terms.

Photography Release

I authorize www.sbcosmeticdentistry.com to use photographs of me to help better understand my current dental condition and possible treatment options. I also authorize them to show these photographs for professional purposes to show to other patients or potential patients.

I also authorize the release of any information necessary of helpful in processing the claim for reimbursement for medical services. This authorization is valid for the release of dental information to all insurance carriers.

As the signer below, I attest that SBGCD or any contracted anesthesiologist has the right to maintain my signature on file for the purposed of filing claims. Additionally, my signature below will act as authorization for today's and future treatments, unless I rescind such authorization in writing.

_____ _____

Printed Name of Patient/Guarantor on the Account Date

_____ _____

Signature of Patient/Guarantor on the Account Date

_____ _____

Relationship if Other than Parent Date