New Patient Intake & Consent

Type into this form on your computer, or print it and write. Bring it to your visit, or fax it to Pearl River (845) 623-7784 · Woodcliff Lake (201) 391-7070. You can also complete it online — it takes about 10 minutes.

ABOUT THE PATIENT

Who is filling out this form?

☐ I am the patient ☐ I'm a parent, guardian or representative of the patient

Title

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Mx. ☐ Dr.

Patient's legal first name

Patient's legal last name

Preferred name

Patient's date of birth

Patient's Social Security number

PARENT, GUARDIAN OR REPRESENTATIVE (IF APPLICABLE)

Your full name

Your relationship to the patient

☐ Parent ☐ Legal guardian ☐ Spouse or partner ☐ Healthcare proxy / power of attorney ☐ Other

Your phone

Your email

CONTACT & ADDRESS

Cell phone

Home phone

Work phone

Email

Best way to reach you

☐ Call my cell ☐ Call my home phone ☐ Text me ☐ Email me

Street address

Apartment, suite, etc.

City or town

State

ZIP code

Is your mailing address the same?

☐ Yes ☐ No, it's different

Mailing address (if applicable)

Person to contact in case of emergency

Relationship

Their phone

YOUR VISIT

Which office are you visiting?

☐ Pearl River, NY ☐ Woodcliff Lake, NJ ☐ Not sure yet

Have you been to our office before?

☐ Yes ☐ No ☐ Not sure

Referring dentist

General dentist

Did your dentist give you a referral slip or X-rays?

☐ Yes ☐ No ☐ Not sure

If you weren't referred, how did you hear about us?

Are you having pain or discomfort at this time?

☐ Yes ☐ No ☐ Not sure

What makes it hurt? (if applicable)

☐ Hot food or drinks ☐ Cold food or drinks ☐ Biting or pressure ☐ It hurts on its own ☐ It wakes me at night

Which tooth or area?

Since when? (if applicable)

Any swelling?

☐ Yes ☐ No ☐ Not sure

Has this tooth had a root canal before?

☐ Yes ☐ No ☐ Not sure

About when? (if applicable)

Does the tooth have a crown (cap)?

☐ No crown ☐ Temporary crown ☐ Permanent crown ☐ Not sure

Anything else you'd like the doctor to know?

MEDICAL HISTORY

Are you under the care of a medical doctor at the present time?

☐ Yes ☐ No

For what purpose? (if applicable)

Your physician's name (if applicable)

Physician's phone (if applicable)

Do you have, or have you had, any of the following?

HEART & CIRCULATION

☐ Heart failure ☐ Heart disease ☐ Heart attack ☐ Heart stent ☐ Angina pectoris ☐ High blood pressure
☐ Heart murmur ☐ Mitral valve prolapse ☐ Rheumatic fever ☐ Congenital heart lesions ☐ Scarlet fever
☐ Artificial heart valve ☐ Heart pacemaker ☐ Heart surgery ☐ Nervousness ☐ Psychiatric treatment

GENERAL HEALTH

☐ Artificial joint ☐ Anemia ☐ Stroke ☐ Kidney trouble ☐ Ulcers ☐ Emphysema ☐ Chronic cough
☐ Tuberculosis (TB) ☐ Asthma ☐ Sinus trouble ☐ Allergies ☐ Thyroid disease
☐ Venereal disease (syphilis, gonorrhea) ☐ Hemophilia ☐ Sickle cell disease

OTHER CONDITIONS

☐ Chemotherapy (cancer radiation therapy) ☐ Arthritis ☐ Glaucoma ☐ Pain in jaw joints ☐ AIDS
☐ HIV positive ☐ Hepatitis A (infectious) ☐ Hepatitis B (serum) ☐ Liver disease ☐ Blood transfusion
☐ Drug addiction ☐ Genital herpes ☐ Epilepsy or seizures ☐ Bruise easily ☐ Diabetes

MEDICINES TO MENTION

☐ Taking blood thinners ☐ Osteoporosis / bone medication (e.g. bisphosphonates)

☐ None of these

When was your artificial joint placed? (if applicable)

Do you need to premedicate (take antibiotics) before dental treatment for any reason?

☐ Yes ☐ No

What do you take, and why? (if applicable)

Do you have any diseases, conditions or problems not listed above?

☐ Yes ☐ No

Please list them (if applicable)

Are you pregnant now?

☐ Yes ☐ No ☐ Not sure ☐ Doesn't apply

Your OB-GYN's name (if applicable)

Are you taking birth control pills?

☐ Yes ☐ No ☐ Doesn't apply

Are you nursing?

☐ Yes ☐ No ☐ Doesn't apply

MEDICATIONS & ALLERGIES

Are you taking any medications at the present time?

☐ I don't take any medications

Are you allergic to, or made sick by, any drugs or medications?

☐ Yes ☐ No ☐ Not sure

Please list them (if applicable)

Are you allergic to latex?

☐ Yes ☐ No ☐ Not sure

Name of pharmacy

Town

INSURANCE & BILLING

Do you have dental insurance?

☐ Yes ☐ No ☐ Not sure

Insurance company (if applicable)

Insurance phone (on the back of the card) (if applicable)

Member ID (if applicable)

Group number (if applicable)

Who is the policy holder? (if applicable)

☐ The patient ☐ Spouse or partner ☐ Parent ☐ Someone else

Policy holder's full name (if applicable)

Policy holder's date of birth (if applicable)

Policy holder's employer (if applicable)

Do you have secondary dental insurance? (if applicable)

☐ Yes ☐ No ☐ Not sure

Insurance company (if applicable)

Insurance phone (on the back of the card) (if applicable)

Member ID (if applicable)

Group number (if applicable)

Who is the policy holder? (if applicable)

☐ The patient ☐ Spouse or partner ☐ Parent ☐ Someone else

Policy holder's full name (if applicable)

Policy holder's date of birth (if applicable)

Policy holder's employer (if applicable)

Patient's employer

Business address

Patient's spouse

Spouse's employer

Spouse's business address

Today's method of payment

☐ Credit card ☐ Check ☐ Other

Other method (if applicable)

RESPONSIBLE PARTY (FOR MINORS) (IF APPLICABLE)

Person responsible for payment of this account

Relationship to patient

Has the responsible party been a patient in our office?

☐ Yes ☐ No ☐ Not sure

Address

Home phone

Work phone

Birthdate

Responsible party's Social Security number

Employer

Employer address

Does the responsible party have insurance?

☐ Yes ☐ No

WHO WE MAY SPEAK WITH

Whom may we speak to regarding your health?

☐ No one — please speak only with me

Name	Phone	Relationship to patient

MEDICAL HISTORY STATEMENT

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I understand that it is my responsibility to advise your office of any changes in my medical history.

X _____ _____

Signature of patient (or parent / guardian if minor) Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected 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 providers who may be involved in that treatment directly and indirectly.
• Obtain payment from third-party payers.
• Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this 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 at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

X _____ _____

Signature of patient (or parent / guardian if minor) Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below. Date: _____ Initials: _____ Reason: _____

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or other health practitioners.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to me or my dependent.

Payment is due at time of treatment unless other arrangements are made in advance. If it becomes necessary to use collection procedures due to non-payment, any and all additional fees, including but not limited to attorney, court and collection agency fees incurred by this office, will also be my responsibility.

X _____ _____

Signature of patient (or parent / guardian if minor) Date

ASSIGNMENT OF INSURANCE BENEFITS (IF YOU HAVE DENTAL INSURANCE)

I authorize and request my insurance company to pay direct to the dentist insurance benefits otherwise payable to me.

X _____ _____

Signature of patient (or parent / guardian if minor) Date

ROOT CANAL TREATMENT CONSENT

Root canal treatment is an attempt to retain a tooth that may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth that has had root canal therapy may require retreatment, surgery, or even extraction.

I also understand that the root canal filling restores only the root portion of the tooth. The crown portion must be restored by an additional procedure, for an additional expense by your dentist. Teeth having pre-existing crowns and/or bridges may require new crowns and/or bridges after completion of root canal therapy.

One of the risks of root canal treatment is an altered sensation or permanent numbness after treatment. Although this is rare, it is a possibility. Another treatment option is extraction. The risk of an altered sensation or permanent numbness is also possible if this tooth is extracted.

X _____ _____

Signature of patient (or parent / guardian if minor) Date

APPOINTMENT REMINDERS AND MESSAGES (OPTIONAL)

I agree that the practice may contact me at the phone numbers and email address I provided — including by text message and automated reminders — about appointments, billing and my care. Message and data rates may apply. I can change my preferences or opt out at any time by telling the office or replying STOP to a text.

X _____ _____

Signature (optional) Date

SIGNER

Printed name

If representative: relationship to patient