Ashford Dental
Dobbs Ferry

NEW PATIENT PACKET

WELCOME

We would like to extend a warm welcome to our practice! Our goal is to help you obtain and maintain your oral health and a beautiful smile. We are committed to making sure each visit with us is comfortable and enjoyable for you!
Please read and fill out each page carefully and completely

Patient Full Name ______________________

Date Of Birth __________ **SSN** __________

Male ☐ **Female** ☐ **Phone #** __________

Email Address __________

Street Address __________

Apt No. __________

City __________ **State** __________ **Zip Code** __________

Occupation __________ **Employer** __________

Dental Insurance Information

Subscriber Full Name __________

Subscriber SSN __________ **Subscriber DOB** __________

Relation to Subscriber Self ☐ Spouse ☐ Child ☐ Other ☐

Insurance Company __________ **Insurance Phone #** __________

Member ID # __________ **Group #** __________

Who may we thank for referring you to our office?

Google ☐ Insurance ☐

Name of person or office referring you __________

Emergency Contact

Name __________

Relation to patient __________

Contact Number __________

DENTAL HISTORY

Office/ Dentist Name __________

Contact # __________

Email Address __________

Date of Last Visit __________

Type of Treatment __________

CURRENT DENTAL HEALTH

Good ☐ Fair ☐ Poor ☐

Are you experiencing any sensitivity in any of your teeth? **Yes** ☐ **No** ☐

Do you have gingivitis or periodontal disease? **Yes** ☐ **No** ☐

Are you experiencing any pain or discomfort in your jaw? **Yes** ☐ **No** ☐

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MEDICAL HISTORY

Medical Physicians Name ______________________

Are you currently under the active care of a physician for any present health issues? If yes, please explain

____

____

I am required to pre-medicate prior to dental appointments **Yes** ☐ **No** ☐

Are you taking any prescription or over the counter medication? If yes, please list each one ______________________

____

ALLERGIES

Aspirin ☐ Latex ☐ Codeine ☐

Sulfa Drugs ☐ Any Metals ☐ Amoxicillin/ Penicillin ☐

Other ______________________________________

Are you pregnant or nursing? **Yes** ☐ **No** ☐

If yes, which trimester? ____________

Do you currently use recreational drugs? **Yes** ☐ **No** ☐

Please indicate if you have/had any of these medical issues:

- ☐ Abnormal Bleeding
- ☐ Alcohol/Drug Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valves
- ☐ Artificial Bones/Joints
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Bone/Joint Disease
- ☐ Bursitis
- ☐ Cancer/Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Frequents Headaches
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes/Fever Blisters
- ☐ High Blood Pressure
- ☐ HIV + AIDS
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Psychiatric Care
- ☐ Radiation Care
- ☐ Rheumatic/Scarlet Fever
- ☐ Shingles
- ☐ Seizures
- ☐ Sickle Cell Disease
- ☐ Sprains/Broken Bones
- ☐ Tendonitis
- ☐ Thyroid Problems
- ☐ Tuberculosis (TB)
- ☐ Ulcers

List any other medical condition(s) or surgeries that you've had:

____

____

HIPPA Consent Form

Under HIPAA, you have the following rights with respect to your health information:

- You have the right to request restrictions on certain uses and disclosures of protected health information, including restrictions placed upon disclosure of protected health information, including restrictions placed upon disclosure of family members, close person friends, or any other person you may identify. We are, however, not required to agree with a requested restriction
- You have the right to receive confidential communications of your protected health information
- You have the right to amend protected health information, however, this may be denied under certain circumstances
- You have the right to receive an accounting of disclosures of your protected health information, either by us in the six years in the six years prior to the date of the accounting request
- You have the right to obtain a paper copy of this notice from us, even if you have already agreed to receive the notice electronically

If you feel your privacy rights or the provisions of this notice or privacy policies have been violated, you have the right to file a formal written complaint. This complaint should be addressed either to the Privacy Officer at our office, or directly to the Department of Health and Human Services, office of Civil Rights. Both addresses appear below. You will not be retaliated against, in any way, for filing a complaint.

I understand that I have certain rights to privacy regarding my protected health information. These are given to me under the Health Insurance Portability and Accountability Act of 1995 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (example: insurance company)
- The day to day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with these restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

For more information about HIPAA
Or to file a complaint contact;

The U.S. Department of Health & Human Services
Offices of Civil Rights
200 Independence Avenue, S.W.
Washington DC 20201
Toll Free (877)696-6775

Patient or Legal Authorized Representative Printed Name ______________________________

Patient or Legal Authorized Representative Signature ______________________ ***Date*** __________

Your Patient Obligations

Cooperation

Successful dental treatment is a team effort involving you as the patient, the doctors and out team. Without cooperation, successful treatment planning, achieving optimal results and successful treatment planning, achieving optimal results and maintaining the treatment results are difficult or impossible and the result may be disappointing to everyone.

Scheduled Appointments

In order to serve our patients better, we strive to operate a professional, efficient dental practice. We attempt to reserve appropriate blocks of time for each of our patients so that the procedures may be completed with close attention to detail and with as few interruptions as possible. Missed appointments have a negative effect on our ability to maintain the level of service you and other patients deserve. While we are aware that circumstances may arise which interfere with set appointments, we require at least two day notice for cancellations. Failure to provide this notice may result in a $75 missed appointment fee, which is not intended as a penalty, but as a reasonable estimate of the time and expense incurred by the Practice in attempting to fill such a cancellation or loss of deposit.

Financial Obligation

You are fully responsible for payment of the dental services that you or your dependents receive in our office. Please understand that payment of your bill is considered part of your treatment.

- Full payment is due at the time of your service
- We offer extended payment plans with Care Credit and Lending Point financing programs

The balance of your treatment service is your responsibility whether your insurance company pays or not. We cannot bill insurance company unless you bring in all insurance information. Your insurance policy is a contract between you and your insurance company, we are not a party of that contract. The estimate provided by this office is considered as a guideline until the final payment is received and the patients account has been reconciled. This office can make no guarantee of the insurance payment as estimated. Claims are submitted promptly after treatment is rendered, and if not paid by the patients insurance company by the 61st day after treatment, will be billed in full to the patient. Our administrative staff prides itself on helping our patients maximize their benefits. We are always available to answer you questions.

We may contact you to provide appointment reminders or to inform you about treatment alternatives or other health related benefits or services that may be of interest to you. We may also contact you for fundraising or promotional purposes.

The information I have provided on this form is accurate and completed to the best of my knowledge. I will notify the Practice of any personal medical or health changes of the information I have provided at my earliest convivence. In consideration of being accepted as a patient to the practice, I agree to abide by the terms and conditions of this Patient Application & Agreement.

By signing below, I acknowledge that I have been given time to read and have completely read (or had read to me) the preceding information in this document and I acknowledge that the Practice has explained to me in general terms the descriptions of certain anticipated dental procedures an treatments, alternatives (including non-treatment) an the risks and inconveniences of treatments. By proceeding with each an every step in my treatment, I acknowledge that: 1. I have been given the opportunity to ask any questions and any questions have been answered or explained to my satisfaction prior to performance of any treatment or procedure and 2. I have recommended forms of treatment, medication and therapy that may be necessary or advised. I understand that during the course of the procedures described above, it may be necessary, appropriate, or recommended at the time this consent is given. I consent to and authorize the performance of such additional procedures as they deem necessary, appropriate or recommended under the circumstances. I herby render the providers of Ashford Dental of Dobbs Ferry, P.C to render my dental treatment.

Patient or Legal Authorized Representative Printed Name ______________________________

Patient or Legal Authorized Representative Signature ______________________ ***Date*** __________

Consent for release of dental records

This form is your written permission, to release or request any radiographic images, dental notes or records we may have on file for you. This form is needed if we may need too refer you to another office for treatment or if you decide to part ways with the practice.

I hereby authorize **Ashford Dental of Dobbs Ferry, P.C** providers and staff to release and/or request any of my dental/medical radiographic images, clinical notes or records on file that are concerning my health.

Printed Patient/Legal Guardian Name ______________________________

Relation to patient ______________ ***Patient/Legal Guardian Signature*** ______________________

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