PATIENT REGISTRATION FORM

LAST NAME | FIRST NAME | MI | DOB | PHONE NUMBER

MAILING ADDRESS | CITY | STATE | ZIP CODE

OCCUPATION | HEIGHT | WEIGHT | SEX

SOCIAL SECURITY # | EMERGENCY CONTACT | RELATIONSHIP | PHONE NUMBER

EMAIL ADDRESS:

***If you are completing this form for another person, please specify your name and relationship to the patient.*

MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

Are you under a physician's care now? ☐YES ☐NO If yes, please explain _____
Have you recently been hospitalized? ☐YES ☐NO If yes, please explain _____
Do you take or have you taken, Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? ☐YES ☐NO If yes, please explain _____
Are you on a special diet of any kind? ☐YES ☐NO If yes, please explain _____
Do you use tobacco? ☐YES ☐NO If yes, how often _____
Are you taking any medications, pills, or drugs? Please list: ☐YES ☐NO If yes, list medications _____

Pregnant / Trying to get pregnant ☐YES ☐NO Taking oral contraceptives? ☐YES ☐NO Nursing ☐YES ☐NO

Are you **allergic** to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain _____

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

☐ AIDS/HIV Positive
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis/Grout
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problem
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disorder
☐ Diabetes
☐ Drug Addiction
☐ Epilepsy/Seizures
☐ Excessive Bleeding
☐ Fainting Spells/Dizziness
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Pacemaker
☐ Heart Trouble/Disease
☐ Hepatitis A, B or C
☐ Herpes
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Hives or Rash
☐ Hypoglycemia
☐ Kidney Problems
☐ Liver Disease
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Pain in Jaw Joints
☐ Psychiatric Care
☐ Radiation Treatments
☐ Rheumatic Fever
☐ Shingles
☐ Sinus Trouble
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Other

DENTAL HISTORY

General Dentist _____ Date of Last Exam _____

Pharmacy: _____

Do your gums bleed while brushing or flossing?	☐ YES	☐ NO
Are your teeth sensitive to hot or cold?	☐ YES	☐ NO
Are your teeth sensitive to sweets?	☐ YES	☐ NO
Do you have pain on any of your teeth?	☐ YES	☐ NO
Do you have any sores or lumps in or around your mouth?	☐ YES	☐ NO
History of any periodontal therapy?	☐ YES	☐ NO
Do you snore or have been told you snore?	☐ YES	☐ NO
Have you received proper hygiene instructions?	☐ YES	☐ NO
Have you had any head, neck, or jaw injuries?	☐ YES	☐ NO
Do you bite your lips or cheeks frequently?	☐ YES	☐ NO
Have you ever had any difficult extractions in the past?	☐ YES	☐ NO
Have you ever had orthodontic treatment?	☐ YES	☐ NO
Have you had prolonged bleeding following dental treatment?	☐ YES	☐ NO
Do you wear a denture or a partial?	☐ YES	☐ NO
Do you clench or grind your teeth?	☐ YES	☐ NO
Have you ever experienced any jaw pain?	☐ YES	☐ NO
Do you have any difficulty opening or closing?	☐ YES	☐ NO
Do you have any difficulty in chewing?	☐ YES	☐ NO

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be added questions concerning your health. This information is vital to allow us to provide proper care for you. This office does not use this information to discriminate

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental offices of anu changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN **DATE**

FOR COMPLETION BY DENTIST
Comments on patient interview concerning health history:
Significant findings from questionnaire or oral interview

INSURANCE INFORMATION

Do you have dental insurance? ☐ YES ☐ NO

Name of Insurance Company: _____

Address: _____ City, State, Zip: _____

Insured name: _____ DOB: _____/_____/_____

SSN#: _____-_____-_____ ID or Group #: _____

Employer: _____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

By my signature below, I affirm the above information.

Signature of Patient: _____ Date: _____

Signature of Guardian / Authorized Representative: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

Regulations require that we make a "good faith" effort to provide you with a copy of our HIPAA Privacy Practices Notice. However, you are not required to accept the Notice, only to acknowledge that we have made you aware of our HIPAA Notice of Privacy Practices.

I, _____, have received a copy of,
[Patient Name]
or acknowledge the existence of Gordon & Maltz, PC HIPAA Notice of Privacy Practices.

_____ _____
Patient Signature Date

I give my permission to release my medical information to:

_____ _____
Name Relationship

_____ _____
Name Relationship

FOR OFFICE USE ONLY

WHEN EFFORTS TO OBTAIN PATIENT ACKNOWLEDGEMENT WERE UNSUCCESSFUL:

NAME OF PATIENT: _____

I provided the above-named patient with the HIPAA Notice of Privacy Practices for Gordon & Maltz, PC on _____.
Date

Describe how Notice was offered or provided:

[ ] Offered copy and patient refused to accept delivery.
[ ] Offered copy and patient accepted delivery but refused to sign.
[ ] Other [describe]:

_____

_____ _____
Employee Signature Date

REV. 04/22/24

Centers for Periodontal Specialty Care & Dental Implants
New City, NY Middletown, NY Poughkeepsie, NY

FINANCIAL POLICY

Thank you for selecting Gordon & Maltz, PC for your periodontal and implant treatment needs! We look forward to working with you. Our objective is to provide you with outstanding dental care. For this reason, we want to provide you a thorough understanding of our financial policy.

The fee for treatment is based upon the complexity of your treatment plan. We will review the fees associated with your treatment plan after our doctor has performed a thorough evaluation of your case. **Payment is due at the time services are rendered.**

You shall be directly responsible for all payments for treatment, regardless of insurance coverage. The office shall make all reasonable attempts to assist with insurance coverage, but the ultimate responsibility for payment remains with the patient or legal guardian.

You may be asked to provide your credit card information on file for payment for treatment. The office will make reasonable attempts to notify you prior to charging your credit card on file, but the office shall have the right to make such charges for services you received and agreed to be financially responsible for, regardless of whether you provide confirmation to the office's attempts to contact you prior to making such charges.

By signing and acknowledging this form, you hereby agree to the following:

I accept financial responsibility for any/all procedures performed by the practice, its doctors and staff.

I accept responsibility for payment of all treatment provided to me regardless of insurance coverage.

I accept responsibility for payment for all treatment for minors for which I am the parent and/or legal guardian.

I hereby provide consent and approval for the office to charge me for reimbursement of any credit card fees and expenses incurred by the office and/or its business support provider in allowing payment by credit card (currently 3%).

Please note that we provide convenient third-party financing options through CareCredit, which we can provide upon request.

DENTAL INSURANCE COVERAGE

If you have dental insurance coverage, please provide all dental insurance information **prior to service** and our office will assist you with filing your insurance claim. Please understand that we will provide an insurance estimate to you. However, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible.

19 Squadron Blvd.
New City, NY 10956
845-634-8807

22 Mulberry St. Suite 2C
Middletown, NY 10940
845-343-0519

305 Titusville Road
Poughkeepsie, NY 12603
845-226-5156

Centers for Periodontal Specialty Care & Dental Implants
New City, NY Middletown, NY Poughkeepsie, NY

It is important to recognize that once we file your insurance claim, we are not responsible for claims that are denied for any reason. The patient is responsible for any balance due if a claim is denied. Please keep in mind that this is only an estimate and coverage verification does not guarantee payment. It also does not guarantee the estimated cost given to you is the total amount due. You agree to pay the BALANCE not paid by your insurance company.

CREDIT CARD SURCHARGE

For use of a credit card, you will be responsible for a 3% reimbursement and/or recovery of credit card and/or merchant fees and expenses as incurred by the Practice.

DEPOSITS:

The following cases will require a deposit of 100% of our fees prior to your appointment on all "Cash" pay patients and 100% of copay/deductible on all insurance patients. This deposit is non-refundable.
*Multiple Teeth/Large Cases

NO SHOW or CANCELLATION:

We ask that you arrive ***10-15 minutes prior to your scheduled appointment time***. If you are late, we will not be able to accommodate you, as you are reducing the necessary time Dr. Maltz set aside to provide quality personalized care for you and affecting his scheduled time with other equally valuable patients. This will result in a ***$75.00 late and cancellation fee for any missed appointments and those cancelled within 72 hours of the appointment time***. This fee will have to be paid before any future appointments are made.

RETURN CHECK POLICY:

There will be a $50 charge for any checks returned for insufficient funds. We also reserve the right to refuse this form of payment in the future.

We reserve the right to send any account to collections that is over 90 days in arrears.

You will be responsible for all costs and expenses for collection, including reasonable attorney's fees.

By signing below, I acknowledge my financial responsibility for all treatments rendered.

_____ _____

Patient Name/Legal Guardian: **Date:**

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