Park One Dental
1601 Jericho Turnpike.
New Hyde Park N.Y. 11040
(516) 354-0033

Name: _____ DOB: ___/___/____
Address: _____ Age: _____
City: _____ State: _____ Zip Code: _____ Cell: _____
Home: _____ Work: _____ Email: _____
Sex: □M □F □Single □Married □Widowed □Divorced
Emergency Contact Name: _____ Telephone: _____
Reason for today's visit: _____ How did you hear about us? _____

Medical History

Physician's Name: _____ Date of last visit: _____

Have you ever had any serious illnesses or operations? _____. If yes, approximate dates: _____

(Women) Are you pregnant? _____ Nursing? _____ Birth Control Pills? _____

Check if you have had any of the following:

_ High Blood Pressure
_ Heart Problems
_ Bleeding abnormally, with extractions, or surgery
_ Stents
_ Stroke
_ Heart Surgery
_ Pacemaker
_ Artificial Heart Valves or joints, screws, etc.
_ Congenital Heart Lesions
_ Low Blood Pressure
_ Thyroid Problems
_ Arthritis Rheumatism
_ Anemia
_ Cholesterol
_ Circulatory Problems
_Cough, Persistent
_ Rheumatic Fever
_ Diabetes
_ Stroke
_ Glaucoma
_ HIV / AIDS
_Kidney Disease
_ Tobacco Habit
_ Jaundice
_ Herpes
_Liver Disease
_ Skin Rash
_ Headaches
_ Cancer
_Venereal Disease
_Asthma
_ Tonsillitis
_ Epilepsy
_Hepatitis
_ Respiratory Disease
_ Ulcer

Latex Allergy □Yes □ No

_ Drug Use
_ Fainting or dizziness
_Jaw Pain
_Psychiatric Care
_Hemophilia
_ Radiation Treatment
_Chemotherapy
_Swollen Neck Glands
_ Emphysema
_ Tuberculosis
_ Chemical Dependency
_ Weight Loss, unexplained
_ Tumor or growth on head or neck
_ Nervous Problems
_Fainting
_Sinus Trouble
_OTHER_____

Medications: _____
Allergies to any medications: _____

CERTIFICATION

To the best of my knowledge, the information I have provided on this form is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand I am solely responsible for any errors or omissions that I must have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have change in health.

Signature: _____ Date: _____

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Authorizations

1. I authorize my insurance company to pay Liberty Dental Care P.C insurance benefits for services rendered. I authorize the use of this signature on all insurance submissions. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in a ca e.

Consent to Treatment

2. I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have the opportunity to discuss and ask questions before any dental treatment is started. Dentistry is usually done under local anesthesia (lidocaine w/ epi). There are risks and complications associated with all dental procedures such as facial numbness, allergic reactions, infection, pain, swelling, damage to the jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

HIPPA

3. I received the notice of privacy practices and I have been provided an opportunity to view it.

4. **24 HOUR NOTICE IS REQUIRED FOR APPOINTMENT CANCELLATIONS OR RESCHEDULING. YOU WILL BE CHARGED $30.00 IF YOU MISS 2 APPOINTMENTS IN A ROW.**

I read page 2 and I understand page 2:

Print name: _____

Signature: _____

Date: _____

Witness: _____ (STAFF USE ONLY)

- *Liberty Dental Care P.C. always verifies that dental insurance is active before any dental work is started. ACTIVE DENTAL INSURANCE AND PRE-AUTHORIZATION FOR DENTAL WORK DOES NOT GUARANTEE PAYMENT! I acknowledge full financial responsibility for services rendered by Liberty Dental Care P.C. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including deductibles and co-pays. I understand payment of deductibles and co-pays is expected at the time of service as well as any other balances I may owe. I understand that if I do not pay my bill, I will be reported to a collection agency, which can affect my credit score.*

YOU MUST INFORM US OF PRIMARY AND SECONDARY DENTAL COVERAGE.

Primary Insurance

Name of Dental Insurance:_____ Phone #: _____

Policy / Member ID: _____ Group/Account #:_____

Policy Holder Information:

Name_____ Date of Birth: _____

Address_____City_____State____Zip__

Relationship_____Soc.Sec#_____Employer_____

Secondary Insurance

Name of Dental Insurance: _____Phone#: _____

Policy / Member ID: _____ Group/Account #_____

Policy Holder Information:

Name: _____ Date of Birth: _____

Address_____City_____State____Zip_____

Relationship_____Soc.Sec#_____Employer_____

I read page 3, I understand page 3:

Print name: _____

Signature: _____

Date: _____

Witness: _____ (STAFF USE ONLY)