Midtown Dental Center
General & Implant Dentistry

Peter M. Engelsberg, D.M.D.
www.MidtownDentalCenter.com

PATIENT INFORMATION FORM

TODAY'S DATE:_____/_____/_____

NAME:(Dr /Mr /Miss /Mrs /Ms) ____
(Please Circle) (First) (MI) (Last)

NICKNAME/PREFERRED NAME:____

ADDRESS:____
(Street) (City/State) (Zip)

ALTERNATE ADDRESS:____
(Street) (City/State) (Zip)

HOME PHONE:(_____)______________________ WORK PHONE:(_____)______________________

ALTERNATE PHONE:(_____)______________________ FAX:(_____)______________________

E-MAIL ADDRESS:____

DATE OF BIRTH:_____/_____/_____ AGE:__________ GENDER: MALE / FEMALE
(Please Circle)

How did you learn of our office?____

What is the reason for your initial visit in our office?____

____

PERSON TO CONTACT IN CASE OF EMERGENCY?______________________ PHONE:______________

OCCUPATION:____

EMPLOYER NAME & ADDRESS:____

PHYSICIAN NAME & CITY:______________________ PHONE:(_____)______________

Are you currently under the care of a physician? (incl. cardiologist/hematologist, etc)............................☐ Yes ☐ No

If yes, please explain:____

When was your last physical examination?__________ Was anything unusual or abnormal found?..............☐ Yes ☐ No

If yes, please explain:____

Have you ever had any operations, hospitalizations or serious illness?..☐ Yes ☐ No

If yes, please explain:____

PHARMACY NAME & LOCATION:______________________ PHONE:(_____)______________

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GENERAL HEALTH QUESTIONNAIRE

PATIENT NAME:____________________________________DATE OF BIRTH_____/_____/_____AGE_____

▶Do you have or have you ever had:

	Yes	No
Rheumatic fever		
Congenital heart disease		
Mitral valve prolapse		
Heart murmur		
Heart valve replacement		
Prosthetic (artificial joints)		
High cholesterol		
Angina (chest pain)		
Irregular heart beat		
Coronary artery disease		
Heart disease/Heart attack		
Cardiac pacemaker		
Swelling of the ankles		
High or Low blood pressure		
Stroke/TIA		
Bleeding problems		
Anemia		
Hemophilia		
Seizures/Epilepsy		
Dizziness/Fainting		
Sexually transmitted disease		
HIV/AIDS		

	Yes	No
Asthma		
Bronchitis/chronic cough		
Shortness of breath		
Emphysema		
Chronic Obstructive Pulmonary Disease		
Recurrent sore throat		
Sleep Apnea		
Tuberculosis		
Sinus problems		
Thyroid disease		
Glaucoma		
Kidney disease		
Liver disease/Hepatitis		
Diabetes		
Ulcers or colitis		
Gastrointestinal problems		
Arthritis/ Joint pain/ Back problems		
Cancer		
Radiation/Chemotherapy treatments		
TMJ symptoms/treatment		
Prostate problems		
Osteoporosis		

▶Are you allergic to or have you had an adverse reaction to:

	Yes	No
Local anesthetics		
Penicillin/Amoxicillin		
Sulfa drugs		
Other antibiotics		
Iodine/Betadine/Neosporin		

	Yes	No
Sedatives, barbiturates		
Codeine		
Other narcotics		
Aspirin or Ibuprofen		
Latex or adhesive tape		

Please list additional allergies:____

▶Are you taking any of the following medications:

	Yes	No
Any type of blood thinners		
Aspirin or Ibuprofen		
Coumadin		
Vitamin E		
Glucosamine		

	Yes	No
Diuretics/Water pills		
Insulin or oral anti-diabetic drugs		
Blood pressure medicine		
Prednisone/steroids		
Medication for osteoporosis		

Please list all current medications:____

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GENERAL HEALTH QUESTIONNAIRE

Is there a past history of alcohol, chemical dependency, psychiatric treatment, nervous or emotional disorder that may affect the care we provide you?............ ☐ Yes ☐ No

Do you smoke or chew tobacco?............ ☐ Yes ☐ No If yes, how much?______________________

Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?... ☐ Yes ☐ No

Have you ever been instructed to take antibiotics before dental treatment?............ ☐ Yes ☐ No

FEMALE PATIENT:
Are you or could you be pregnant? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No

FOR YOUR INFORMATION
Antibiotics may interfere with the effectiveness of oral contraceptives.

Do you have any other disease, condition or problem not listed above that you think the Doctor should know about?............ ☐ Yes ☐ No

If yes, please list:____

The disclosure of medical information is for your general welfare, whether you are here for diagnostic consultation, a simple extraction or a major dental procedure. Your general health may have a significant affect on your current condition and on the outcome of any proposed treatment. For the good of your overall health and safety, please answer all questions.

I CERTIFY THAT THE MEDICAL HISTORY I HAVE GIVEN ABOVE IS CORRECT:

X ______________________________ ______________________
Patient's Signature (Parent/Guardian, if minor) Date

DOCTOR'S REVIEW:

▶ ______________________ ____________
Doctor's Signature Date

ASSISTANT'S REVIEW:

▶ ______________________
Assistant's Signature

Notice of Privacy Practices:

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a Notice of Privacy Practices. Our Notice is available on-line. If you do not have internet connectivity, please ask one of our staff for a copy of our Notice.

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X ______________________________ ______________________
Patient's Signature (Parent/Guardian, if minor) Date

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FINANCIAL INFORMATION FORM

PATIENT INFORMATION

Name ______________________________ Male ____ Female ____

Address ______________________________

E-mail address ______________________________

Date of Birth ____________ Telephone#s ____________ ____________ ____________
home work cell

Place of Employment ____________ Occupation ____________ Soc. Sec. # ____________

Driver's License # ______________________________

GUARANTOR OF ACCOUNT
(if other than the patient)

Name ______________________________ Male ____ Female ____

Relationship to Patient ______________________________

Address ______________________________

E-mail address ______________________________

Date of Birth ____________ Telephone#s ____________ ____________ ____________
home work cell

Place of Employment ____________ Occupation ____________ Soc. Sec. # ____________

Driver's License # ______________________________

DENTAL INSURANCE INFORMATION

Insurance Company Name ______________________________

Claims Address ______________________________

Group # ____________ Company Toll Free Phone # ____________

Policy Holder's Name ______________________________

Date of Birth ____________ SS # ____________ Employer ____________

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FINANCIAL RESPONSIBILITY

Thank you for choosing us as your dental care provider. The following information provides the basis for the financial aspect of your treatment. We sincerely desire to treat our patients in a pleasing and congenial atmosphere and find this can best be accomplished when a clear understanding exists regarding financial arrangements. Please contact the office at any time with questions regarding your financial responsibility.

▪PAYMENT: Fees for services are due when treatment is rendered. Payment may be made in cash, check, or by credit card. We also offer financing through Capital One or Care Credit.

▪INSURANCE: If you have dental insurance, we will make a good faith estimate of your benefits and defer billing you for that amount up to 30 days. We will file the appropriate claim forms with your insurance company, provided you supply us with documented evidence of coverage, ie an insurance card. If your insurance provider denies coverage or if we otherwise do not receive payment within 30 days from the date services are rendered, the amount will then become due and payable by you. Although we will make every effort to help you understand and obtain your benefits, we cannot guarantee your insurance provider will pay. The amount of reimbursement is determined by the insurance carrier. We do not accept responsibility for collecting on an insurance claim or for negotiating a settlement on a disputed claim.

▪THIRD PARTY PAYMENT: If the Guarantor of Account is someone other than the patient, financial arrangements must be made prior to treatment being provided.

▪NON-PAYMENT: In the event the charges incurred are not paid in full when due and collection action is instituted, the patient is responsible for the additional costs associated with such collection activity. The collection costs may include and are not limited to collection agency fees, attorney fees, court costs and/or any other expenses incurred in its collection as allowable by law.

▪RETURNED CHECKS: A $25 processing fee will be charged for a returned check.

▪INTEREST: Any account remaining unpaid 30 days from date of service will be charged interest at the rate of 1.5% per month on any unpaid balance (18% per year) unless prior payment arrangements have been approved.

▪CANCELLATION: Patients are expected to notify the office at least 48 hours prior to their scheduled appointment if they cannot keep the appointment. Failure to properly notify the office may result in a charge of $80 per hour of scheduled appointment time. Three non-notified missed appointments may result in dismissal from the practice.

FINANCIAL RESPONSIBILITY AGREEMENT

I have read the financial responsibility for dental services, agree to the terms and accept full responsibility for all charges for services rendered.

Patient or Authorized Representative Signature:________________________________ Date:__________

Relationship to Patient:____