

54 S Liberty Drive Stony Point, NY 10980 Phone: 845-429-1300 www.royparkdss.com

Welcome to our practice! Our goal is to provide you with the best care so please help us in doing so by completing all <u>four</u> forms. All information is completely confidential. We look forward to seeing any friends or family you refer to our office. **Thank you!**

Patient Information

Name (Last, First, Middle):			Date:		
Nickname:	DOB:	Age:_	Sex: □Male □Female	•	
Social Security Number:					
Home Phone:					
Address:		_City:	State:Zip (Code:	
Employer:	Occupation:		Employer Phone:		
How did you hear about us?□Onlin	ne or □Live	in the area	or Referred By:		
Emergency Contact Name and Pho	one Number:				
	Dental	Insurance			
Account Holder Name:	D	OB:	Relationship to Patient:		
Social Security or Member ID Nur	nber:		Phone Number:		
Employer:]1	□ Full Time □	☐ Part Time ☐ Retired		
Insurance Company:					
Address:	(City:	State:	Zip(Code:
	Do	you have a	secondary insurance? (Circle:	Yes
	No				
Account Holder Name:	D	OB:	Relationship to Patient:		
Social Security or Member ID Nur	nber:		Phone Number:		
Employer:	[□ Full Time □	☐ Part Time ☐ Retired		
Insurance Company:	Grou	p Number:	Phone:		
Address:	(City:	State:	Zip (Code:
	 Denta	l History			
What is the reason for your visit too		•			
Previous Dentist:	Date of Las	t Cleaning:	Date of Last X-	Rays:	
Are you feeling sensitivity to hot/c					
Are you experiencing jaw pain/clic	-	-			
Are you having difficulty opening.			_		
Are you having difficulty chewing			-		
Do you smoke, chew tobacco, or v	·		-		
Do you smoke, chew tobacco, or v	ape! Yes INO	Please spec	erry which, now long, and of	rten:	
Do you have a family history of:	Oral Cancer	Gum disease	□Excessive cavities	□Not sure	
Are you satisfied with the appeara	nce of your teeth?	□Yes □l	No		
Are you interested in whitening?	Yes □No				



Medical History

Fainting or Dizzy Spells Yes No Tuberculosis Yes No Freq Heartburn/Reflux/GERD Yes No Ulcers Yes No Glaucoma Yes No Unexplained Weight Loss Yes No Hay Fever Yes No Venereal Disease Yes No Heart (Surgery, Disease, Attack) Yes No WOMEN: Are you pregnant? Yes No Due date Taking birth control pills? Yes No Nursing Yes No 10. If you have any disease, condition, or problem not listed above, please explain: I understand the above information is necessary to provide me dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you	Physician_		Office Phone		Date of last physi	ical	
2. Have you been hospitalized for any surgical operation or serious illness within the last 5 years?□Yes □No Reason 3. Do you need to be PREMEDICATED before dental treatment?□Yes □No Reason 4. Have you ever taken prescription medication for weight loss (e.g. Fenphen, Redux)?□Yes □No 5. Have you ever used bisphosphonate medication? (e.g. Fosamax, Actonel, Boniva, Prolia)□Yes □No 6. Are you currently taking blood thinners, including aspirin? □Yes □No If yes please list name, reason, and dosage: 7. If not answered above, are you taking any medication, drugs or pills now (including regular doses of vitamins, herbals and homeopathic meds)?□ Yes□ No If yes, list name, dosage and reason: 8. Are you ALLERGIC to or have had an adverse reaction to any of the following? □Aspirin □Codeine □Local anesthetic (e.g. Novocaine) □Penicillin or other antibiotics □Sulfa drugs □Latex Other 9. Please circle "Yes" or "No" to indicate if you have had any of the following: AlDS/HIV Positive Yes No Heart Murmur Yes No Antificial Heart Valves Yes No Heart Pacemaker Yes No Artificial Heart Valves Yes No Heaptitis (Type: □ Yes No Artificial Ident Valves Yes No High Blood Pressure Yes No Artificial Ident Valves Yes No Low Blood Pressure Yes No Ashtma Yes No Low Blood Pressure Yes No Chemolical Dependency Yes No Pacemaker Yes No Chemical Dependency Yes No Pacemaker Yes No Chemical Dependency Yes No Radiation Therapy Yes No Chemical Dependency Yes No Radiation Therapy Yes No Congenital Heart Lesions Yes No Radiation Therapy Yes No Congenital Heart Lesions Yes No Radiation Therapy Yes No Congenital Heart Lesions Yes No Radiation Therapy Yes No Congenital Heart Lesions Yes No Radiation Therapy Yes No Congenital Heart Lesions Yes No Radiation Therapy Yes No Congenital Heart Lesions Yes No Radiation Therapy Yes No Congenital Heart Lesions Yes No Radiation Therapy Yes No Congenital Heart Lesions Yes No Radiation Therapy Yes No Congenital Heart Lesions Yes No Radiation Therapy Yes No Congenital Heart Lesions Yes No Rad	1. Are you under medical treatmen	nt now				-	•
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6. Are you currently taking blood thinners, including aspirin? □Yes □No If yes please list name, reason, and dosage: 7. If not answered above, are you taking any medication, drugs or pills now (including regular doses of vitamins, herbals and homeopathic meds)?□ Yes□ No If yes, list name, dosage and reason: 8. Are you ALLERGIC to or have had an adverse reaction to any of the following? □Aspirin □Codeine □Local anesthetic (e.g. Novocaine) □Penicillin or other antibiotics □Sulfa drugs □Latex Other 9. Please circle "Yes" or "No" to indicate if you have had any of the following: AlDS/HIV Positive Yes No Heart Murmur Yes No Anemia Yes No Heart Pacemaker Yes No Artificial Heart Valves Yes No Heart Pacemaker Yes No Artificial Joints(Year? Yes No Kidney Disease Yes No Artificial Joints(Year? Yes No Kidney Disease Yes No Bleeding Abnormally Yes No Low Blood Pressure Yes No Anemial Yes No Low Blood Pressure Yes No Cancer Yes No Mitral Valve Prolapse Yes No Chemical Dependency Yes No Pacemaker Yes No Chemical Dependency Yes No Pacemaker Yes No Chemical Dependency Yes No Pacemaker Yes No Chest Pain Yes No Radiation Therapy Yes No Congenital Heart Lesions Yes No Rheumatic Fever Yes No Congenital Heart Lesions Yes No Rheumatic Fever Yes No Congenital Heart Lesions Yes No Sinus Trouble Yes No Sinus Trouble Yes No Congenital Heart Lesions Yes No Sinus Trouble Yes No Contisone Treatments Yes No Sinus Trouble Yes No Sinus Trouble Yes No Contisone Treatments Yes No Sinus Trouble Yes No Sinus Trouble Yes No Contisone Treatments Yes No Sinus Trouble Yes No Heart (Surgery, Disease, Attack) Yes No Uncers Yes No Uncers Yes No Heart (Surgery, Disease, Attack) Yes No Uncers Yes No Uncers Yes No Heart (Surgery, Disease, Attack) Yes No No Nursing Yes No Heart (Surgery, Disease, Condition, or problem not listed above, please explain: □ understand the above information is necessary to provide me dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be neede	4. Have you ever taken prescription	n med	dication for weigh	t loss (e.g. Fenph	en, Redux)?□Yes	□No	
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Print patient name (or parent if minor) Signature of patient (or parent if minor)	v		v		Do	ite	
	Print patient name (or parent if mi	nor)	^ Sionatur	e of patient (or p	arent if minor)		



HIPPA Consent

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, as well as the uses and disclosures we may make of your protected health information or other important matters pertaining to your health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes many apply to any of your protected health information that we maintain.

Consent will not affect any action we took in relying on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

(print name) have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand hat, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.				
x_ Signat	ure of patient (or parent if minor)			
	FOR OFFICE USE ONLY			
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but				
acknowledgment count not be obtained because:				
	Individual refused to sign			
	Communication barriers prohibited obtaining the acknowledgement			
	An emergency situation prevented us from obtaining acknowledgement			
	Other (Please specify below)			



AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize this dental practice to apply for benefits on my behalf for covered services rendered.

I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical or dental information for this or any related claim, to my insurance carrier. A copy of the authorization may be used in place of the original.

may be used in place of the original.	
Either my insurance carrier or I may revoke this author	ization at any time in writing.
xSignature of patient, insured or beneficiary	Date
ASSIGNMENT OF B	ENEFITS
I hereby authorize payment of all dental insurance bene terms of my insurance policy to be paid directly to this authorize the release of any information needed for pro this authorization maybe used in place of the original.	dentist for services rendered. I further
xSignature of patient, insured or beneficiary	Date
FINANCIAL AGRE	EMENT
I hereby assume financial responsibility for and agree to DDS, for all charges for services or dental supplies furrauthorized or paid by my insurance carrier. Payment is the statement, unless payment arrangements are made verifinancial information given is true, accurate and completurther authorize Roy H. Park, DDS to investigate any at this or related claims.	nished the above named not otherwise to be made within 30 days of receipt of with the business office. I certify that the ete, to the best of my knowledge, and
xSignature of patient, insured or beneficiary	Date

ADA.

Patient Screening Form

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

• For testing, see the list of State and Territorial Health Department Websites for your specific area's information.