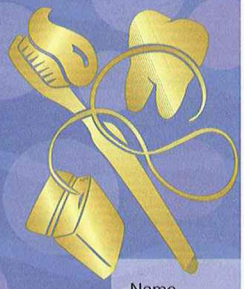


Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address *(if different from patient)* _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address *(if different from patient)* _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

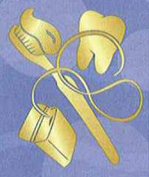
Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.



Dental History

What would you like us to do today?_____ Are you in dental discomfort today? _____

Former Dentist _____ Address_____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays_____

Check (✓) yes or no if you have had problems with any of the following:

❑Y ❑N Bad breath ❑Y ❑N Food collection between teeth ❑Y ❑N Periodontal treatment ❑Y ❑N Sensitivity to sweets

❑Y ❑N Bleeding gums ❑Y ❑N Grinding or clenching teeth ❑Y ❑N Sensitivity to cold ❑Y ❑N Sensitivity when biting

❑Y ❑N Clicking or popping jaw ❑Y ❑N Loose teeth or broken fillings ❑Y ❑N Sensitivity to hot ❑Y ❑N Sores or growths in mouth

How often do you brush? _____ Floss?_____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑Y ❑N

Other information about your dental health or previous treatment_____

Medical History

Physician's name _____ Phone _____

Address _____ Email _____

Date of last visit _____ Have you had any serious illnesses or operations? ❑Y ❑N

If yes, describe _____

Are you currently under physician care? ❑Y ❑N If yes, describe _____

Have you ever had a blood transfusion? ❑Y ❑N If yes, give approximate dates_____

Have you ever taken Fen-Phen/Redux? ❑Y ❑N

Women: Are you pregnant? ❑Y ❑N Nursing? ❑Y ❑N Taking birth control pills? ❑Y ❑N

Check (✓) yes or no whether you have had any of the following:

❑Y ❑N AIDS/HIV Positive
❑Y ❑N Anaphylaxis
❑Y ❑N Anemia
❑Y ❑N Arthritis, Rheumatism
❑Y ❑N Artificial heart valves
❑Y ❑N Artificial joints
❑Y ❑N Asthma
❑Y ❑N Atopic (allergy prone)
❑Y ❑N Back problems
❑Y ❑N Blood disease
❑Y ❑N Cancer
❑Y ❑N Chemical dependency
❑Y ❑N Chemotherapy
❑Y ❑N Circulatory problems
❑Y ❑N Cortisone treatments

❑Y ❑N Cough, persistent
❑Y ❑N Cough up blood
❑Y ❑N Diabetes
❑Y ❑N Epilepsy
❑Y ❑N Fainting
❑Y ❑N Food allergies
❑Y ❑N Glaucoma
❑Y ❑N Headaches
❑Y ❑N Heart murmur
❑Y ❑N Heart problems
Describe _____
❑Y ❑N Hemophilia/ Abnormal bleeding
❑Y ❑N Herpes
❑Y ❑N Hepatitis

❑Y ❑N High blood pressure
❑Y ❑N Jaw pain
❑Y ❑N Kidney disease or malfunction
❑Y ❑N Liver disease
❑Y ❑N Material allergies (**latex**, wool, metal, chemicals)
❑Y ❑N Mitral valve prolapse
❑Y ❑N Nervous problems
❑Y ❑N Pacemaker/ Heart surgery
❑Y ❑N Psychiatric care
❑Y ❑N Rapid weight gain or loss
❑Y ❑N Radiation treatment
❑Y ❑N Respiratory disease
❑Y ❑N Rheumatic/Scarlet fever

❑Y ❑N Shingles
❑Y ❑N Shortness of breath
❑Y ❑N Skin rash
❑Y ❑N Spina Bifida
❑Y ❑N Stroke
❑Y ❑N Surgical implant
❑Y ❑N Swelling of feet or ankles
❑Y ❑N Thyroid disease or malfunction
❑Y ❑N Tobacco habit
❑Y ❑N Tonsillitis
❑Y ❑N Tuberculosis
❑Y ❑N Ulcer/Colitis
❑Y ❑N Venereal disease

Is patient currently taking any medications? If yes, list all:

_____

_____

Does patient have drug allergies? If yes, list all:

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date_____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

FLOWER HILL DENTAL GROUP

Michael Azrolan, D.D.S.
Renee Choe, D.D.S
Effie Ahladiotis, D.M.D.
Erica Sutter, D.D.S

Lee Nissensohn, D.D.S.
Peter Rybak, D.D.S.
Tascha Fuchs, D.D.S.
Dana Marzocco D.M.D

1025 Northern Blvd., Suite 91
Roslyn, NY 11576

OFFICE (516) 365-7777
FAX (516) 869-8550

FINANCIAL POLICY

We would like to advise you that having insurance coverage does NOT indicate being covered at 100% for all services. Whereas some procedures may be paid in full, most of your treatments will be covered at a percentage of the charge. It is **your** responsibility to pay any co-payment amount and/or a deductible according to your insurance policy. If for any reason your insurance does not pay their portion within 60 days after your procedure, you will be responsible for that part as well.

In order to control our billing costs, we request that your portion of the charges be paid at the end of each visit unless other arrangements are made in advance. Please note that you will also be responsible for any service not covered or denied by your insurance company.

For your convenience, we will accept cash, checks and all major credit cards. Checks returned for insufficient funds will be charged a $35.00 fee.

Because of the nature of our practice, we reserve a specific amount of time for each patient depending on the treatment. This time is extremely valuable to us. Appointments cancelled without a 24-hour notice will incur a $50.00 broken appointment fee. Accumulation of broken appointments may lead to our refusal to accept you as a patient.

If you have an outstanding balance over 90 days, a finance charge will be applied to your account according to New York State laws, unless you have a payment plan with us. Please do not hesitate to ask us about financial arrangements that we can offer to help you pay off large balances.

_____ _____

Patient's Signature
(Parent/guardian if minor)

Date

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (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 (e.g. my 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 any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my 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 this restriction.

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.

Printed name: _____

Relationship to patient: _____

Signature: _____

Date: _____

Flower Hill Dental Group
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Roslyn, NY 11576