

Chart #: _____
FOR OFFICE USE ONLY

PATIENT INFORMATION

Date: _____

Patient Name: _____
Last, First, MI (Preferred Name)

Social Security # _____ Birth Date ____ / ____ / ____ Driver's License # _____

Phone (Home) _____ (Work) _____ (Cel) _____

(E-mail) _____

What is your preferred method of communication? Home Phone Work Phone Cel E-mail

Address _____ Apartment # _____

City _____ State _____ Zip Code: _____

I prefer to be addressed on correspondence as _____ in person _____

Spouse's Name _____

Marital Status:

- Married Separated Single
- Divorced Widowed Engaged

Employer _____ Occupation _____

Bus. Phone _____

In case of Emergency, call _____ Cell _____

Phone _____ Address _____

(Name of close relative NOT living at your home address.)

Name _____

Phone _____ Address _____

Whom may we thank for referring you?

Name _____

Phone _____ Address _____

Did you visit our web site? www.midtowndentistry.com Yes No

DENTAL INSURANCE INFORMATION

Do you have dental insurance? Yes No

If yes: Name of Primary Carrier _____

Address _____

Group Insurance No. _____ ID # _____

Do you have medical insurance? Yes No

If yes: Name of Primary Carrier _____

Address _____

Group Insurance No. _____ ID # _____

Is your treatment accident related? Yes No

If yes: Date of Accident _____

Attorney handling the accident _____

(name) _____ (phone number) _____

Signature _____ Date: _____

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

- | Y | N | Condition |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypoglycemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle cell anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Leukemia |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting spells |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina pectoris |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial heart valve |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Bacterial endocarditis |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital heart defect |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Other heart ailment |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty breathing/shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies or Hay fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Respiratory disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Intestinal disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach/GI disorders |

- | Y | N | Condition |
|--------------------------|--------------------------|---------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Anorexia or Bulimia |
| <input type="checkbox"/> | <input type="checkbox"/> | Other eating disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Head Injury |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric problems/Nervous disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizure |
| <input type="checkbox"/> | <input type="checkbox"/> | Alzheimer's disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatism |
| <input type="checkbox"/> | <input type="checkbox"/> | Prosthetic joint replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis/Osteopenia |
| <input type="checkbox"/> | <input type="checkbox"/> | Tumor or growth |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Cosmetic surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney problems/Disease/Dialysis |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid or Parathyroid disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes - Insulin dependent |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes - Oral medication |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis, Liver disease (A/B/C) |
| <input type="checkbox"/> | <input type="checkbox"/> | Venereal disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS/ HIV positive |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex allergy |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever blister |
| <input type="checkbox"/> | <input type="checkbox"/> | Xerostomia (dry mouth) |
| <input type="checkbox"/> | <input type="checkbox"/> | Burning tongue |

MEDICATIONS

Are you sensitive or allergic to any medications?

Penicillin Yes No Sulfa Drugs Yes No

Tetracycline Yes No Codeine Yes No

Have you ever had penicillin? Yes No

Do you have any tattoos or body piercing? Yes No Location? _____

Does exposure to the sun cause you to break out? Yes No

Do you wear contact lenses? Yes No

Have you ever taken: Aredia Zometa Fosamax Actonel Boniva Fen-Phen Date: ___/___/___

Please list any additional medications and reason for use:

Medication:	Dosage/Number of years	Prescribing doctor	Reason for use
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CONSENT FOR INTERNET COMMUNICATIONS

I grant my permission to Jonathan Penchas, DMD, PA or Midtown Dentistry to upload and store confidential patient information - including account information, appointment information and clinical information - to the secured web site for Midtown Dentistry. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand Midtown Dentistry and myself are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that Midtown Dentistry is not liable for any charges, damages or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand Midtown Dentistry is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the Midtown Dentistry web site with my ID and password I also agree to immediately notify Midtown Dentistry of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand Midtown Dentistry will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Midtown Dentistry has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information.

E-mail Address _____

Signature _____ Date _____

FINANCIAL POLICY

We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile with respect to your budget.

DENTAL INSURANCE

We Cannot guarantee any estimate coverage. Midtown Dentistry does not accept insurance on assignment. We will bill your primary insurance company as a COURTESY to you. You agree to pay for all services at the time services are rendered and the amount that the insurance determines to be eligible will be reimbursed to you by the insurance company. Finance charges will be assessed on accounts over 90 days past due.

PAYMENTS

Check: A **\$25.00** fee will be assessed on all returned checks. Credit Cards: For your convenience we accept MasterCard, Visa, Discover and American Express. On treatment involving laboratory fees: (crowns, bridges, dentures, and veneers) You may choose to pay 50% on the preparation date and the balance in two weeks. (See Treatment Plan Coordinator) I understand that payment is due when services are rendered, unless prior arrangements have been made.

CANCELLED/RESCHEDULED/MISSED APPOINTMENTS

We realized our patients have very busy schedules. We work hard to keep your wait to a minimum and find appointment times convenient for you and your family. However, all cancellations, reschedules and missed appointments (without a twenty four (24) hour notice) are subject to 50% of the cost of the appointment. Please be considerate of our time, as we will be of yours.

For all Cleaning / Hygiene appointments missed there will be a fee of \$40.00 assessed to your account if not canceled within twenty four (24) hours.

I am aware that Jonathan Penchas DMD, PA or Midtown Dentistry is **NOT** a Participating Provider with any dental, medical, or health insurance company, including Medicare and Medicaid. I am also aware and understand that I am fully responsible for all financial aspects of any services and treatment I receive. Even though Jonathan Penchas DMD, PA or Midtown Dentistry does not accept insurance for its services and treatment, Jonathan Penchas DMD, PA or Midtown Dentistry may submit a claim to my insurance company on my behalf at my request, in an effort to assist in obtaining insurance reimbursement directly to me. It is understood that even with this courtesy, it is my responsibility to pay for all financial aspects of any services and treatment I receive.

Failure to provide at least 24 hours notice of appointment cancellation will result in a cancellation fee. ___ INITIAL

Signature _____ Date _____

CONSENT FOR DENTAL TREATMENT

I _____ hereby authorize any treatment necessary as related to the dental care of the patient whose name appears on this health history form and grant authority to administer such anesthetics, analgesics, sedatives and nitrous oxide sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I understand that there are possible adverse effects of the procedures, anesthetics and/or drugs to be employed. I understand that dentistry is not an exact science and that reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that treatment may have complications. I accept the common risks and complications associated with dental treatment including teeth sensitivity, the need for root canal treatment, gingival/gum problems and TMJ problems. I have had the opportunity to read this form and ask questions. I ask and give my consent to Doctors Penchas, Ward and Scheyer, other doctors, health care providers and staff in his office to treat me as their patient. My questions have been answered to my satisfaction. I certify this form has been fully explained to me, that I have read it or have had it read to me, and that I am not under the influence of any drugs and I understand its contents. I agree to be responsible for payment of all services rendered on my behalf.

Signature _____ Date _____

CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I understand there may be other problems associated with my oral condition that may be addressed at a later date. I understand that no warranty or guarantee has been made to me as to result, cure, or longevity of dental work. I give my permission to the Dentist and such associates, assistants, and other health care providers to make any/all changes and additions as necessary.

Signature _____ Date _____

PHOTOGRAPHS

I authorize Midtown Dentistry to take photographs, slide photos, and/or video tape of my teeth, jaws, and face. I understand that these photographic materials will be used as a record of my treatment, and may be used for educational purposes in lectures, presentations marketing materials, advertisements, and professional publications. I further understand that all reasonable attempts will be made to conceal my identity.

Signature _____ Date _____

DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the doctor of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

Signature _____ Date _____

PLEASE READ THE FOLLOWING STATEMENTS REGARDING NOTICE OF PRIVACY PRACTICE

TO THE PATIENT

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 health care 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 health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. 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 may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person _____

Telephone _____ Fax: _____

E-mail _____

Address _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance 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.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, 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.

Signature _____ Date _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name _____ Relationship to Patient _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

