FF FT QS IP



Plattsburgh 675 State Rte. 3 Suite 201 Plattsburgh N.Y. 12901 518-563-8622 (Phone) 518-562-8623 (Fax)

Gender: Fermale Family Status:	Patient Name:								
Gender: Fernale Family Status:	Social Security #: Birth Date: Best time to call:								
Gender: Fermale Family Status:	Social Security #: Birth Date: Phone (Home): (Work): Ext: Best time to call:								
Gender: Female	Social Security #: Birth Date: Phone (Home): (Work): Ext: Best time to call:								
Phone (Home):	Phone (Home): (Work): Ext: Best time to call:								
Address: Street									
Address: Street	F Mail.								
Address: Street									
Street City State Zip Code	L-Iviaii								
City State Zip Code	Address:								
Health Information	Street Apartment #								
Health Information	City State Zip Code								
Date of Last Dental Visit:									
Have you ever had any of the following? Please check those that apply: AIDS									
□ AIDS									
□ Allergies □ Growths □ Due date: □ Penicillin Allergy □ Anemia □ Hay Fever □ Radiation Treatment OTHER: □ Arthritis □ Heart Disease □ Rheumatic Fever □ Artificial Joints □ Heart Murmur □ Rheumatism □ Asthma □ Hepatitis □ Sinus Problems □ Cancer □ Jaundice □ Stroke □ Diabetes □ Kidney Disease □ Tuberculosis □ Dizziness □ Liver Disease □ Tumors □ Excessive Bleeding □ Nervous Disorders □ Ulcers □ Fainting □ Pacemaker □ Venereal Disease • Have you ever had any complications following dental treatment? □ Yes □ No If yes, please explain: □ Heave you been admitted to a hospital or needed emergency care during the past two years? □ Yes □ No • Name of Physician: □ Phone:									
Hay Fever	5 ,								
□ Anemia □ Head Injuries □ Respiratory Problems □ Arthritis □ Heart Disease □ Rheumatic Fever □ Arthritis □ Heart Murmur □ Rheumatism □ Asthma □ Hepatitis □ Sinus Problems □ Blood Disease □ High Blood Pressure □ Stroke □ Chew □ Cancer □ Jaundice □ Stroke □ Chew □ Diabetes □ Kidney Disease □ Tuberculosis □ Dizziness □ Liver Disease □ Tumors □ Excessive Bleeding □ Nervous Disorders □ Ulcers □ Excessive Bleeding □ Nervous Disorders □ Ulcers □ Fainting □ Pacemaker □ Venereal Disease • Have you ever had any complications following dental treatment? □ Yes □ No If yes, please explain: □ Yes □ No • Name of Physician: □ Phone: □ Yes • Name of Physician: □ Phone: □ Phone: • Do you have any health problems that need further clarification? □ Yes □ No	· · · · · · · · · · · · · · · · · · ·								
□ Arthritis □ Heart Disease □ Rheumatic Fever □ Artificial Joints □ Heart Murmur □ Rheumatism □ Asthma □ Hepatitis □ Sinus Problems □ Blood Disease □ High Blood Pressure □ Stroke □ Cancer □ Jaundice □ Stroke □ Diabetes □ Kidney Disease □ Tuberculosis □ Dizziness □ Liver Disease □ Tumors □ Epilepsy □ Mental Disorders □ Ulcers □ Excessive Bleeding □ Nervous Disorders □ Ulcers □ Fainting □ Pacemaker □ Venereal Disease • Have you ever had any complications following dental treatment? □ Yes □ No If yes, please explain: □ Yes □ No • Name of Physician: □ Phone: □ Phone: □ Yes □ No If yes, please explain: □ Yes □ No	Anomio Decoriretory Problems								
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□ Blood Disease □ High Blood Pressure □ Stomach Problems □ Smoke □ Cancer □ Jaundice □ Stroke □ Chew □ Diabetes □ Kidney Disease □ Tuberculosis □ None □ Dizziness □ Liver Disease □ Tumors □ Excessive Bleeding □ Nervous Disorders □ Ulcers □ Excessive Bleeding □ Nervous Disorders □ Ulcers □ Venereal Disease □ Have you ever had any complications following dental treatment? □ Yes □ No If yes, please explain: □ Yes □ No If yes, please explain: □ Phone: □ Name of Physician: □ Phone: □ Do you have any health problems that need further clarification? □ Yes □ No If yes, please explain: □ Yes □ No	D Acthma D Hopetitic D Sinus Problems DO YOU USE TODACCO	<u>?</u>							
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If yes, please explain:									
Medications									
	Medications								

Spouse or Responsible Party Information The following is for: the patient's spouse the person responsible for payment Name: Male Female Married Single Child Other Social Security #: Birth Date: Phone (Home): (Work): Ext: Best time to call: Address: Apartment # City State Zip Code Employment Information The following is for: the patient the person responsible for payment Employer Name: Occupation:	Call:Apartment #	nformation Child □ Other _ Best time to c	ponsible Party ponsible for payment arried □ Single Birth Date: Ext:	Spouse or Response or the person response	ollowing is for: the patient's spone:
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The following is for:	Call:Apartment # Zip Code	Child □ Other _ Best time to c	ponsible for paymen arried □ Single Birth Date: Ext:	spouse the person res	ollowing is for: the patient's spone:
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Name: Male	Call:Apartment # Zip Code	_ Best time to c	arried □ Single Birth Date: Ext:	☐ Ma	ne: Male
□ Male □ Female □ Married □ Single □ Child □ Other Social Security #:	Call:Apartment # Zip Code	_ Best time to c	Birth Date: Ext:	(Work):	☐ Male ☐ Female al Security #: ne (Home):
Address: Street Apartment #	Apartment # Zip Code	_ Best time to c	Ext:	(Work):	ne (Home):
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The following is for: ☐ the patient ☐ the person responsible for payment Employer Name: Occupation: Address:					
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Address:			, ,	·	
Street City, State Zip Code Phone					
	Phone	State Zip Code	(Street
Did you give card to front desk staff to copy?				Did you give card	ary
	atient?	_ is insured a pa	MI	First	ie of Insured:
		Group #:			Last
Insured's Birth Date: ID #: Group #:		o a.p			red's Birth Date:
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Last First MI Group #: ID #: Group #:	Zip Code	State	City		red's Birth Date: red's Address: red's Employer Name: Address:
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Medical Insurance Did you give card to front desk staff to copy?

Name of Insured:		_ is insured a patient? ☐ Yes ☐ N	lo
Insured's Birth Date: ID #:			
		· -	_
Insured's Address:	City	State Zip Code	_
Insured's Employer Name:			_
Address:			_
Insurance plan name and phone number:			
	ent for Services	The marking	
As a condition of your treatment by this office, financial ar reimbursement from the patients for the costs incurred in			
must be determined before treatment.		, , , , , , , , , , , , , , , , , , , ,	•·· p •···
All emergency dental services, or any dental services per	formed without pre	evious financial arrangements, must	be paid for in
cash at the time services are performed.		V	•
Patients who carry dental insurance understand that all de	ental services furni	shed are charged directly to the pat	ient and that
he or she is personally responsible for payment of all dent	tal services. This	office will help prepare the patients i	insurance
forms or assist in making collections from insurance comp However, this dental office cannot render services on the			
A service charge of 1½% per month (18% per annum) on			
days, unless previously written financial arrangements are		e will be charged on all accounts ex	Ceeding oo
I understand that the fee estimate listed for this dental car	re can only be exte	ended for a period of six months from	n the date of
the patient examination.	o dan only bo one	shada for a portoa or olx months ho.	II tilo dato oi
In consideration for the professional services rendered to	me or at my requ	est, by the Doctor, Lagree to pay the	erefore the
reasonable value of said services to said Doctor, or his as	ssignee, at the time	e said services are rendered, or with	nin five (5)
days of billing if credit shall be extended. I further agree to objected to, by me, in writing, within the time for payment			
condition hereunder shall not constitute a waiver of any fu			
including but not limited collections fees from a third party			
I grant my permission to you or your assignee, to telephor	ne me at home or	at my work to discuss matters relate	ed to this form.
I have read the above conditions of treatment and payme	nt and agree to the	pir content	
Thave read the above conditions of treatment and paymen	nt and agree to the	ontoni.	
	Date:	Relationship to Patient: _	
Signature of patient, parent or guardian	Date		
	Date:	Relationship to Patient:	
Signature of guarantor of payment/responsible party			

Consent to use by High Peaks Dental

of Photograph, Likeness, Picture, Comments, Testimonial, Or Voice

I do hear here by fully and freely consent to the use, by High Peaks Dental or its agents and assigns, of my photograph, picture, name, name, comments, testimonial, and/ or promotion or advocacy of High Peaks Dental.

I do hereby release and hold harmless High Peaks Dental, and/ or its agents and assigns from any liability with regards to the above stated purposes arising out of said consent or use. I hereby grant to High Peaks Dental and/ or its agents and assign the right to use, my photograph or likeness, picture, name, comments, testimonial, and/ or voice to advertise and publicize the interests of High Peaks Dental.

Date:

Signature:

I give High Peaks Dental the permission for my child to be photographed, filmed and auto recorded with the understanding that the photos and videos may be used by High Peaks Dental on their social media tools or for other promotions. By signing this document, I expressly grant permission for High Peaks Dental to use any video or voice recordings, and/ or photographs without prior notice or my expressed approval. I further understand that High Peaks Dental will not inform me in advance of each occasion that my child's photo, voice, video and/or likeness is used as described above.

Date:

Signature of Parent or Guardian:

Signature of Parent or Guardian: