FF FT QS IP

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

## Patient Information

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

Gender: *Female* Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

**E-Mail:**_____

Address: _____
Street Apartment #

_____
City State Zip Code

## Health Information

Date of Last Dental Visit: _____

**Have you ever had any of the following? Please check those that apply:**

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

☐ _____

**Do You Use Tobacco?**

- ☐ Smoke
- ☐ Chew
- ☐ None

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

**Medications**

**Referral Information**

Whom may we thank for referring you to our practice? _____

Name of person or office referring you to our practice: _____

## 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: _____

Street Apartment #

_____

City State Zip Code

## Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

## Dental Insurance Information
## Did you give card to front desk staff to copy?

**Primary**

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Phone Number: _____

**Secondary**

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and phone number: _____

## Medical Insurance
## Did you give card to front desk staff to copy?

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Insurance plan name and phone number: _____

### Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay any and all fees including but not limited collections fees from a third party or reasonable fee if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____Date: _____Relationship to Patient: _____
Signature of patient, parent or guardian

_____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:**_____