Patient Information

Date _____

4388 Middle Settlement Rd.
New Hartford, NY 13413
(315) 724-3108

Name _____)
Last *First* *M(initial)*
Preferred Name: _____
Birthdate _____ **Social Security** _____
Circle One Married / Single / Minor **Circle One** Male / Female

Address _____
City _____**State** _____**Zip** _____

Phone Numbers: **Home**: _____ **Cell:** _____ **Work**: _____

Preferred Way of Contact: Home / Cell / Work / Email **Name of Employer:** _____

Email Address: _____
If patient is a minor, **Parent or Guardian's Name**: _____
Responsible Party: Self / Mother / Father/ Other Name: _____

Emergency Contact Information

Name: _____ Relationship: _____

Home #: _____ Cell #: _____

Work #: _____ Best to call: Home / Cell / Work

Whom May We Thank For Referring You?

Family/Friend _____ Radio TV Postcard Facebook Internet

Insurance Information

Policy Holder Name: _____ Insurance Company: _____

Policy Holder Birthdate: _____ Insurance Id #: _____

Employer: _____ Insurance Group #: _____

Insurance Phone #: _____

Assignment And Release

I certify that I (or my dependent) have insurance coverage and that assignment of benefit will be payable to me for services rendered. I understand that I am financially responsible for all charges. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Relationship to Minor (if applicable)_____

Responsible Party Signature: _____ Date: _____

Patient Medical History

Are you currently under the care of a physician? Yes or No Height: _____ Weight: _____
Physician's Name: _____ Physician Phone# _____

Are you taking any drugs or medications? Yes or No
If so, please specify: _____
_____

Are you allergic to any medications? Yes or No
If so, please list:_____
_____

Conditions

Abnormal Bleeding	Y or N	Fainting Spells	Y or N	Mitral Valve Prolapse	Y or N
Alcohol Abuse	Y or N	Fever Blisters	Y or N	Pace Maker	Y or N
Allergies	Y or N	Freq. Headaches	Y or N	Pneumocystitis	Y or N
Anemia	Y or N	Glaucoma	Y or N	Psychiatric Problems	Y or N
Angina Pectoris	Y or N	Hay Fever	Y or N	Radiation Therapy	Y or N
Arthritis	Y or N	Heart Attack	Y or N	Rheumatic Fever	Y or N
Artificial Heart Valve	Y or N	Heart Surgery	Y or N	Seizures	Y or N
Asthma	Y or N	Hemophilia	Y or N	Shingles	Y or N
Cancer – Chemo	Y or N	Hepatitis A	Y or N	Sinus Problems	Y or N
Colitis	Y or N	Hepatitis B	Y or N	Stroke	Y or N
Congenital Heart def	Y or N	High Blood Pressure	Y or N	Thyroid Problems	Y or N
Cosmetic Surgery	Y or N	HIV + AIDS	Y or N	Tuberculosis	Y or N
Diabetes	Y or N	Kidney Problems	Y or N	Ulcers	Y or N
Drug Abuse	Y or N	Liver Disease	Y or N	Venereal Disease	Y or N
Emphysema	Y or N	Low Blood Pressure	Y or N	Yellow Jaundice	Y or N
Epilepsy	Y or N	**Do you smoke or use tobacco?**		**Y or N**	

Do you have any disease/condition/problem not listed above? Please list:_____
_____

For Women: ☐None ☐Nursing ☐Taking Birth Control ☐Pregnant : How many months? _____

**Signature: _____ Date: _____

Smile Evaluation

1.	Do you dislike the color of your teeth?	Yes or No	***Circle if Any Concerns***
2.	Do you have spaces between your teeth that bother you?	Yes or No	
3.	Do you have chips or uneven edges on your teeth?	Yes or No	Fear of Treatment
4.	Do you feel that your teeth are too long or too short?	Yes or No	Time of Tx Concerns
5.	Do you have dark fillings that show when you smile?	Yes or No	Financial Concerns
6.	Do your gums show too much when you smile?	Yes or No	Distance to Office
7.	Are your teeth crowded or crooked?	Yes or No	Not understanding Tx
8.	Do you have existing crowns or dental work you consider "ugly"?	Yes or No	Embarrassment
9.	Has anyone (family member, friend, etc.) ever suggested that you should have something done with your teeth/smile?	Yes or No	Other: _____
10.	Do you avoid smiling when you have your picture taken?	Yes or No	_____
11.	Would you like to improve your existing smile?	Yes or No	_____
12.	Do you wish you had a "New Smile"?	Yes or No	

Aesthetic Oral Arts

Timothy A. Pfister, D.M.D & Associates
4388 Middle Settlement Rd - New Hartford, NY 13413
Tel: 315-724-7121

Financial Policy Agreement

Thank you for choosing our office for your dental care. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy Agreement which we require you to read and sign prior to treatment.

Full payment is due at the time of service.
We accept cash, check, Discover, VISA, and MasterCard.
We offer CareCredit (Patient no interest and extended fixed interest payment plans) with prior credit approval, which allows you to start your treatment today and spread the payments over time.

Service Charge: If I do not pay the entire new balance within 25 days of the monthly billing date a service charge of 1.5% will be added to my account which is an annual percentage rate of 18%. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to affect collection of this account or future outstanding accounts.

Regarding Insurance: We file insurance as a courtesy for our patients. However, we do require co-payment to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and all perhaps, of the services provided may be non-covered services and not considered reasonable and necessary under medical or dental insurance. Our practice is committed to providing the best treatment possible for our patients and our fees are based upon that service.

Minor Patients: The adult accompanying the minor and the parents (or legal guardian) are responsible for payment. You may use the payment methods described above on this page.

Scheduled Appointments: Treatment appointments over $500 must be secured with a 10% reservation fee to keep our schedule predictable. Unless canceled at least 2 business days prior to appointment, a portion of the reservation fee may be forfeited. Please help us to serve our patients better by keeping your scheduled appointments.

Thank you for understanding our financial policy. Please let us know if you have any questions.
I have read, understand, and agree to this "Financial Policy Agreement."

_____ _____

(Patient or Guardian) (Date)

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITES IN THE FUTURE.**

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents, and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT, &BILLING INFORMATION** VIA:

☐ Any of the following ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text Message ☐ Email

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** TO BE CONVEYED VIA:

☐ Any of the following ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text Message ☐ Email

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS, OR NEW HEALTH INFO** ON BEHALF OF THIS HEALTHCARE FACILITY VIA:

☐ None of the following (Opt Out) ☐ All of the following ☐ Phone ☐ Text Message ☐ Email

_____

I understand that **photographs**, video, testimonials, x-rays and other records may be made during the course of my dental examination, treatment, and follow-up care. By signing below, I give permission for such items to be used for purposes of research, advertisement, education, or publication in professional journals.

_____

Patient Signature

In signing this HIPAA Acknowledgement Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.