CRESTWOOD DENTAL
40 Fisher Avenue
Tuckahoe, N.Y. 10707
(914) 793-4411

WELCOME AND THANK YOU FOR SELECTING OUR OFFICE FOR YOUR DENTAL CARE.

Patient Information

Date_____

Patient's Name _____Male [ ] Female [ ]
Last First Middle Nickname

Address _____ E-Mail_____
Street City State Zip

Home Phone_____ Work Phone _____Cell Phone_____

Birth Date _____ Social Security #_____Marital Status: [S] [M] [D][W]

Employer's Name & Address_____

Occupation_____

If child, give parent's or guardian's name_____

Account Information

Person financially responsible for this account:

Name_____ Relationship to patient_____
Last First Middle

Address_____E-mail_____
Street City Zip

Home Phone_____ Work Phone_____Cell Phone_____

Social Security Number_____ Birth Date_____

Employer's Name & Address_____

Occupation_____

Emergency Notification Information
In case of an emergency, who should be notified?

Name_____Relationship to patient_____Phone_____

Getting To Know You

Whom may we thank for referring you to our office?

Their Name_____

How were you referred to our office? _____

MEDICAL HISTORY

Correct answers to the following questions will allow us to provide the accepted dental care and treatment at every visit. Your answers are for our records only and will be considered confidential.

Please list all medications you are currently taking and the reason why you are taking them:

Medication name: **Reason you are taking medication:**

_____

_____

_____

_____

Physician's name: _____ Phone#_____

Date of last medical exam_____

Have you been hospitalized in the past 3 years? Yes [ ] No [ ]

If yes, for what? _____

Have you ever had to take antibiotics (premedication) prior to a dental procedure? Yes [ ] No [ ]

If yes, for what medical condition did you need to do this? _____

Do you still need to take antibiotics (premedication) prior to dental procedures? Yes [ ] No [ ]

Are you taking aspirin? Yes [ ] No [ ]

Are you taking coumadin or another blood thinner? _____

Circle any of the following, which you have had or have at the present:

Anemia	Heart Murmur	Artificial Heart Valve
Diabetes	Heart Failure	Artificial Joints (Hip, Knee, Etc.)
Blood Transfusion	Heart Attack	Mitral Valve Prolapse
Hepatitis A (infectious)	High Blood Pressure	Pacemaker
Hepatitis B (serum)	Glaucoma	Abnormal bleeding from a cut

A.I.D.S. or A.I.D.S. related illness

Please give us any other medical information you feel may be important for us to know about.

_____

_____

Please circle any of the following medications that you are allergic to or have had and adverse reaction to.

Aspirin	Nitrous Oxide	Valium	Local Anesthetic
Percodan	Erythromycin	Penicillin	(Novocain, Xylocaine)
Codeine	Tetracycline	Other Antibiotics_____	other drugs_____

For women only: Are you pregnant? Yes [ ] No [ ] Trimester_____

Obstetrician's Name _____Phone _____

Are you taking birth control pills? Yes [ ] No [ ] (the use of antibiotics can affect their effectiveness)

To the best of my knowledge all the preceding answers are true and correct. I will inform your office of any changes in my medical history at my next visit.

Signature of Patient or Guardian _____Date_____

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Last Name: _____ First Name: _____ M.I. ____

Your Dental History

What is the reason for your dental visit today?_____

_____

Have you had any complications due to dental treatments?.....Yes No
Do you have a high level of anxiety toward dental treatment?..... Yes No
Do you have existing dental work?..... Yes No
Have you ever had problems with local anesthetic?..... Yes No
Have you ever been diagnosed with gum disease?..... Yes No
Do your gums bleed while brushing, flossing, or on their own?.....Yes No
Are any of your teeth loose?.....Yes No
Does food get caught between your teeth or is it difficult to
floss any area?..... Yes No
Are any of your teeth sensitive to hot or cold?..... Yes No
Are you currently having any tooth or jaw pains?..... Yes No
Do you have frequent headaches, earaches, or neck pain?..... Yes No
Have you ever had TMJ treatment for your jaw?..... Yes No
Have you had your wisdom teeth removed?..... Yes No
Have you had braces?..... Yes No
Are you happy with your smile?..... Yes No
Would you like straighter teeth?..... Yes No
Are you happy with the color of your teeth?..... Yes No
Are you interested in cosmetic dentistry?..... Yes No

Please list what you would like to change about your smile: _____

_____

Please tell us any other concerns about your dental treatment: _____

_____

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PATIENT HIPAA AWARENESS

With my permission, Crestwood Dental may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Crestwood Dental's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Crestwood Dental reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Crestwood Dental may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Crestwood Dental may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and or Confidential.

With my permission, the office of Crestwood Dental may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Crestwood Dental restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Crestwood Dental to use and disclosure my PHI for TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

Crestwood Dental Services
40 Fisher Ave.
Tuckahoe, N.Y. 10707
(914)793-4411

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT IS REQUIRED AT THE TIME OF YOUR VISIT

We now offer the following payment options:

____Payment by cash
____Payment by check
____Payment by credit card

Please make your choice, sign below and return to the office manager before treatment.
Thank you.

_____
Please print your name here and sign below

X_____ Date_____