ABOUT YOU:
Date: _____
Name: _____ ○ Male ○ Female
Address: _____
_____
E-mail Address: _____ Social Security # _____
Home # ( ) _____ Pager/ Cell # ( ) _____
Work # ( ) _____ ext: _____ May we call there? _____
Birthdate: _____ Age: _____ Height: _____ Weight: _____
○ Single ○ Married ○ Separated ○ Divorced ○ Widowed
Whom may we thank for referring you? _____
Present Dentist: Name _____ How long? _____
Address _____ Phone # _____

IF THIS APPOINTMENT IS FOR YOUR CHILD OR MINOR:
Date: _____
Name: _____ ○ Male ○ Female
Address: _____
_____
Social Security # _____ Home # ( ) _____
Birthdate: _____ Age: _____ Height: _____ Weight: _____
Whom may we thank for referring? _____
Present Dentist: Name _____ How long? _____
Address _____ Phone # _____

PARENT/GUARDIAN INFORMATION:
Who is responsible for this account: _____
Name: _____ Relationship to Patient _____
Address: _____
Home # ( ) _____ Pager/ Cell # ( ) _____
Work # ( ) _____ ext: _____ May we call there? _____
I / we parent or guardian of _____ hereby permits Barry P Levin,DMD, PC to treat our child/minor. Signature _____Date _____

INSURANCE INFORMATION: Primary Insurance
Name of insured_____Birthdate _____ Relationship _____
Social Security # _____Employer _____
Ins.Co.Name/ Address: _____ ** please provide copy of card/form**
_____ Phone # _____
Policy # _____ Group # _____

Secondary Insurance
Name of insured_____ Birthdate _____ Relationship _____
Social Security # _____Employer _____
Ins.Co.Name/ Address: _____ ** please provide copy of card/form**
_____ Phone # _____
Policy # _____ Group # _____

PATIENT REGISTRATION HISTORY

questions may seem to have nothing to do with your oral condition, they may be contributing influences.
All material will be held in strictest confidence.

Family Doctor Name: _____ **Family Doctor #:** _____

Family Doctor Address: _____

Do you consider yourself to be in good health? YES NO
Have you been under a physicians care recently? YES NO

If yes, when/why_____

Are you taking any medications (including aspirin, vitamins, herbals) YES NO

If yes, which ones_____

_____

Do you smoke? NO YES – **if yes, how much** _____
Have you ever had abnormal bleeding associated with previous surgeries or trauma? YES NO

If yes, when/why_____

Do you need to PRE-MEDICATE with ANTIBIOTICS prior to dental treatment? YES NO

If yes, why and what medication/dosage do you take_____

PLEASE CHECK ANY CONDITION, ILLNESS OR TREATMENT YOU HAVE HAD OR HAVE NOW:

○ **heart disease**	○ **rheumatic fever**	○ **osteopenia**
○ **pacemaker**	○ **rheumatism**	○ **osteoporosis**
○ **heart murmur**	○ **stroke**	○ **sinus problems**
○ **mitral valve prolapse**	○ **diabetes**	○ **allergies**
○ **heart valve prosthesis**	○ **thyroid disease**	○ **epilepsy**
○ **congenital heart lesions**	○ **hepatitis**	○ **fainting spells**
○ **angina**	○ **liver disease**	○ **cancer treatment**
○ **high blood pressure**	○ **gall bladder disease**	○ **melanoma**
○ **low blood pressure**	○ **kidney disease**	○ **joint replacement**
○ **HIV positive**	○ **ulcers**	○ **arthritis**
○ **venereal disease**	○ **tuberculosis**	○ **glaucoma**
○ **anemia**	○ **emphysema**	○ **substance abuse**
○ **hemophilia**	○ **persistent cough**	○ **psychiatric care**
○ **blood transfusion**	○ **asthma**	○ **high cholesterol**

PLEASE CHECK ANY DRUGS YOU ARE ALLERGIC TO OR HAVE HAD A REACTION TO:

○ **local anesthesia**	○ **sulfa**	○ **latex**
○ **aspirin**	○ **iodine**	○ **sedatives**
○ **penicillin**	○ **insulin**	○ **codeine**

OTHER _____

Is there any condition not mentioned above that I should know about? YES NO

If yes, please explain_____

WOMEN
Are you pregnant now? NO YES-**if yes, what is your due date**_____
Are you taking birth control pills? YES NO
Have you ever noticed spotting/bleeding between periods? YES NO
Have you undergone or are you undergoing menopause? YES NO

If yes, are there any symptoms? _____

I authorize Barry P.Levin,DMD, PC to obtain/release information that may be needed in connection with my condition.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ **DATE:** _____

REVIEWED BY: **DATE**

BARRY P LEVIN, DMD, PC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this consent form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

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 healthcare operations of the uses and disclosures we make of your protected health information, and of other important matters about your protected health information.

I have had the full opportunity to read and understand the 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 healthcare operations.

Signature: _____

Date: _____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my Consent.

Signature: _____

Date: _____

BARRY P. LEVIN, D.M.D. FINANCIAL POLICY

Patient Name_____ **Responsible Party**_____

Thank you for choosing us as your health care provider. We are committed to providing the best possible treatment for our patients. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment.

*** FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE.
*** WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS.
*** WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL
*** INTEREST OF 1.5 % IS CHARGED MONTHLY ON ALL BALANCES OVER 60 DAYS

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INSURANCE BENEFITS: We cannot submit a claim to your insurance company without the proper information. In the case where your insurance company requires a claim form, we also ask that you bring a completed and signed form. If you change your insurance company or if your insurance company changes its forms or procedures or imposes additional or different requirements in the future, you will provide all necessary information and sign all appropriate documents. Your insurance policy is a contract between you and your insurance company, and we are not a party to that contract.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best possible treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any arbitrary determination by your insurance company of what is usual and customary. Unless we are participating with your insurance plan, we require that all co-payments and/or deductibles be paid at the time of services unless other arrangements have been made.

MINOR PATIENTS: The parent/guardian accompanying a minor child is responsible for payment.

***MISSED APPOINTMENTS*: SURGERY APPOINTMENTS REQUIRE A MINIMUM OF FORTY-EIGHT (48) HOURS NOTICE OF CANCELLATION. IN THE ABSENCE OF ADEQUATE NOTICE, A CHARGE OF 30% OF THE ANTICIPATED FEES WILL BE INCURRED. HYGIENE APPOINTMENTS REQUIRE A MINIMUM OF TWENTY-FOUR (24) HOURS NOTICE OF CANCELLATION. IN THE ABSENCE OF ADEQUATE NOTICE, A CHARGE WILL BE INCURRED FOR THE FULL FEE.**

LEGAL ACTION: If it were to become necessary to take legal measures to satisfy a delinquent account, all legal and court expenses would be added to the balance due.

I have read and understand this Financial Policy, and I agree to be bound by its terms.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Visa, Master Card,Discover or American Express Card # Exp. Date