South Shore Dental Care, P.C.
Dr. Dory Stutman
Dr. Khalida Stutman
4600 SUNRISE HWY • MASSAPEQUA PARK NY 11762

MEDICAL HISTORY

DATE _____

PATIENT NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ BUSINESS PHONE _____

CELL PHONE _____ E-MAIL _____

EMPLOYER _____

S.S.# _____ BIRTH DATE _____

SEX ☐ MALE ☐ FEMALE MARITAL STATUS _____

DENTAL INSURANCE

DENTAL INSURANCE (PRIMARY) _____

SUBSCRIBER NAME _____

INSUREDS EMPLOYER ADDRESS _____

_____

GROUP # _____

SUBSCRIBER S.S.# _____ D.O.B. _____

INSURED WORK # _____

DENTAL INS. (SECONDARY) _____

SUBSCRIBER S.S.# _____ D.O.B. _____

SUBSCRIBER NAME _____

PHYSICIAN NAME _____

PHYSICIAN NUMBER _____

WHO MAY WE THANK FOR REFERRING YOU ? _____

_____

SIGNATURE OF THE PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT. X _____

REASON FOR TODAY'S VISIT. _____

MEDICAL HISTORY - Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you, it is necessary to have the following information.

HAVE YOU EVER OR NOW HAVE (Please check yes or no):

Y	N		Y	N		Y	N	
☐	☐	Allergies to Medicine	☐	☐	Diabetes	☐	☐	Kidney Disease
☐	☐	Allergy to Penicillin	☐	☐	Drug or Alcohol Abuse	☐	☐	Leukemia
☐	☐	Anemia	☐	☐	Emotional Disturbance	☐	☐	Mental Retardation
☐	☐	Arthritis	☐	☐	Epilepsy	☐	☐	Oral Ulcers
☐	☐	Asthma	☐	☐	Eye Problem	☐	☐	Orthopedic Problems
☐	☐	Bladder Conditions	☐	☐	Excessive Bleeding Problem	☐	☐	Pacemaker
☐	☐	Blood Pressure Problems	☐	☐	Fainting or Dizziness	☐	☐	Pneumonia
☐	☐	Blood Transfusions	☐	☐	Frequent Infections	☐	☐	Rheumatic Fever
☐	☐	Birth Defects	☐	☐	Hay Fever	☐	☐	Scoliosis (Curved Spine)
☐	☐	Bone or Joint Problems	☐	☐	Hearing/Speech Problem	☐	☐	Sickle Cell Anemia
☐	☐	Brain Injury	☐	☐	Heart Murmur/Heart Defects	☐	☐	Sinus Problems
☐	☐	Bruising Easily	☐	☐	Heart Surgery	☐	☐	Thyroid Problems
☐	☐	Cancer or Malignancies	☐	☐	Hemophilia	☐	☐	Tuberculosis
☐	☐	Cerebral Palsy	☐	☐	Hepatitis or Liver Disease	☐	☐	Ulcers/Stomach Problems
☐	☐	Chronic Headaches	☐	☐	HIV Positive	☐	☐	Venerial Disease/Herpes
☐	☐	Cleft Lip/Palate	☐	☐	Implants	☐	☐	Other _____
☐	☐	Convulsions/Seizures	☐	☐	Jaundice			_____

Do wounds heal slowly or present complications? ☐ Yes ☐ No

Presently taking medication? (Please Specify) _____

Presently under a physician's care? ☐ Yes ☐ No

When was your last physical exam? _____

Have you ever been hospitalized? Date (s) _____ Reason (s) _____

Have you ever had x-ray treatment or chemotherapy? ☐ Yes ☐ No

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that has not been covered: _____

_____

(OVER)

MEDICAL HISTORY

South Shore Dental Care, P.C.
Dr. Dory Stutman
Dr. Khalida Stutman
4600 SUNRISE HWY • MASSAPEQUA PARK NY 11762

DATE OF LAST DENTAL EXAM ______________

DATE OF LAST FULL MOUTH X-RAY ______________

OFFICE TAKEN______________

		YES	NO
1.	Have you had trouble from previous dental care? When? Explain.		
2.	Do you have pain in your jaw or near your ears?		
3.	Do you have any unhealed injuries or inflamed areas in or around your mouth?		
4.	Have you experienced any growths or sore spots in your mouth?		
5.	Does any part of your mouth hurt when clenched?		
6.	Have you ever had Novocaine or other local anesthetic?		
7.	Have you ever had Nitrous Oxide (laughing gas)?		
8.	Have you ever had general anesthesia?		
9.	Have you ever had any reaction/allergic symptoms to Novocaine, local or general anesthetic?		
10.	Have you ever had any difficult extractions in the past?		
11.	Have you ever had prolonged bleeding following extractions in the past?		
12.	Do your gums bleed?		
13.	Do you have a bad taste in your mouth or mouth odor?		
14.	Have you ever had instructions on the care of your gums?		
15.	Do you chew on only one side of your mouth? If so, why?		
16.	Do you habitually clench or grind your teeth during the night or day?		
17.	Is any part of your mouth sensitive to pressures or irritants (hot, cold or sweets)? Where?		

Is there any other problem not covered above that you would like to discuss?______________

____

I acknowledge that the information above on the reverse side is correct:

______________ PATIENT SIGNATURE (Parent if Patient is a Minor) DATE

______________ DOCTOR SIGNATURE DATE

FUTURE RECALL MEDICAL HISTORY UPDATES

I have reviewed my MEDICAL HISTORY and my health status and medication ☐ Has NOT Changed ☐ Has Changed
Explain ______________
PRINT NAME ______________ SIGNATURE ______________ DATE ______________ DR. ______________

I have reviewed my MEDICAL HISTORY and my health status and medication ☐ Has NOT Changed ☐ Has Changed
Explain ______________
PRINT NAME ______________ SIGNATURE ______________ DATE ______________ DR. ______________

I have reviewed my MEDICAL HISTORY and my health status and medication ☐ Has NOT Changed ☐ Has Changed
Explain ______________
PRINT NAME ______________ SIGNATURE ______________ DATE ______________ DR. ______________

I have reviewed my MEDICAL HISTORY and my health status and medication ☐ Has NOT Changed ☐ Has Changed
Explain ______________
PRINT NAME ______________ SIGNATURE ______________ DATE ______________ DR. ______________

I have reviewed my MEDICAL HISTORY and my health status and medication ☐ Has NOT Changed ☐ Has Changed
Explain ______________
PRINT NAME ______________ SIGNATURE ______________ DATE ______________ DR. ______________

NEW PATIENT ACCOUNT INFORMATION

Who is responsible for the dental investment?

Last Name First Name M.I.

ADDRESS CITY STATE ZIP

(___)_____ (___)_____ _____

CELL PHONE NUMBER HOME NUMBER EMAIL ADDRESS

S.S.# DRIVER'S LICENSE ID#

First Visit Examination and Payment Information: Policies and Agreement

We accept payment by: CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, CARE CREDIT

Initial visit entails a comprehensive dental examination to formulate a thorough diagnosis and treatment plan. The examination includes a full series of intraoral radiographs, photographs or limited treatment if needed to relieve pain or discomfort.

- ***I authorize any intraoral radiographs, photographs and supportive documentation necessary for a complete diagnosis and proper dental treatment.***
- ***I authorize the release of any necessary information including the diagnosis and records of treatment to third party payers and/or other health practitioners.***

Patients with insurance are expected to pay the **copayment and deductible at the time of service**. Patients without insurance are expected to pay the **pre-determined fee at the time of service**.

Your insurance coverage is a contract **between you and your insurance company, not our office.** Insurance companies reimburse at various amounts based on each individual contract. HAVING INSURANCE IS NOT A SUBSITUTE FOR PAYMENT OR CHARGES AND YOU ARE RESPONSIBLE FOR FULL PAYMENT OF YOUR ACCOUNT WITHIN 45 DAYS OF SERVICE, REGARDLESS OF THE STATUS OF ANY INSURANCE CLAIM.

- ***I have read and understood the above polices and authorizations. I agree to be ultimately responsible for all services rendered on my behalf or my dependent.***

X_____ X_____

Signature of patient or parent of minor **Date**

INSURANCE AGREEMENT

Thank you for choosing South Shore Dental Care for your dental health needs. Excellence in dentistry and patient satisfaction are our utmost priority. It is our goal to provide you with the best quality dental treatment.

As a service to our patients, we will prepare all of the necessary insurance forms. However, we remind you that your policy is an agreement between you or your employer and your insurance company, not between your insurance company and our office.

We can make no guarantee of any estimated coverage, but we will do our best to see that you receive your maximum benefits. Please keep in mind that you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated. If you would like to know what your expected coverage will be, we will submit a pretreatment estimate. Your insurer will generally send a detailed response within four to six weeks.

I acknowledge that I have read the above statement.

_____

Signature Date

APPOINTMENT POLICY

Because we reserve time exclusively for each patient, we ask that, if possible, you not change your appointment. If you can't keep your scheduled appointment, we require a minimum of 48 hours notification so we can make your reserved time available for other patients. To notify us of any change, please call our office during business hours or leave us a message.

In order to maintain the most efficient schedule for our patients, our Appointment Policy is as follows:
- Broken appointments (without 48-hour notification) may incur a fee of **$75.00 per scheduled hour.**

I acknowledge that I have read the above statement.

_____

Signature Date

PHOTOGRAPHY AGREEMENT

Dr. Stutman often takes photographs for the purpose of case documentation, laboratory communication, continuing education, lectures and slide presentations, as well as various dental articles and publications including before and after photos on our website.

I hereby grant permission to South Shore Dental Care, to use any and all photography for the purposes stated above. I also acknowledge that this is done voluntarily and without compensation.

_____

Signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third –party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Name _____ Date _____

Signature _____ Relationship _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____