The Schoengold Group

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last First MI (Nickname)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____(Work): _____Ext:_____ (Mobile): _____

Occupation: _____ E-MAIL Address _____

Address: _____
Street Apartment #

City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

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

☐ AIDS/HIV
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Allergy to other medications_____
_____
☐ Heart Disease
☐ Mitral Valve Prolapsed
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure

☐ Excessive Bleeding
☐ Artificial Joints
☐ Diabetes
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Dizziness
☐ Epilepsy
☐ Fainting
☐ Glaucoma

☐ Growths
☐ **Halitosis/Bad Breath**
☐ Hay Fever
☐ Head Injuries
☐ 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
☐ Ulcers
☐ Venereal Disease
☐ Scarlet Fever
Other: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Are you currently taking any medications ? ☐ Yes ☐ No If so, which ones?_____
  _____
- Have you ever taken the drug Plavix ☐ Yes ☐ No
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient ☐ Dental Office ☐ Google ☐ Internet ☐Facebook ☐ School ☐ Work ☐ 1800Dentist

☐ Other_____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

Insurance Information

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 Address: _____

_____

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 Address: _____

_____

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 all costs and reasonable attorney fees 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 agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

The Schoengold Group
New Patient Discovery

Tell us about yourself. ***(Are you married, have any children?)***

Do you see yourself keeping your teeth for the rest of your life?

What do you want to do with your mouth? *(Are you looking for function or cosmetics?)*

What do you like or dislike about your smile? (*ie Whiter, Close Spaces, Crowding*)

How do you feel about going to the dentist?

How frequently have you gone to the dentist?

When was your last visit to the dentist?

For what purpose?

Have you had any bad past dental experiences?

What dental problems have you had in the past?

What dental problems are you currently experiencing and how do these problems affect you?

How is your parents' dental health?

How often do you brush your teeth and how often do you floss?

Do your gums bleed when you brush and floss? _____

Regarding Finances

What is most important to you regarding finances and dental treatment, another way to put this is how can we help make your visits more affordable?

_____ Date: _____
Signature of patient, parent or guardian

The Schoengold Group FINANCIAL POLICY

Dear Patient:

Thank you for choosing us as your dental care provider. The following is our Financial Policy. Therefore, if you have any questions or concerns about our payment policies, do not hesitate to ask our front desk personnel.

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the doctor.

Payment for services is due at the time services are rendered. We accept cash, checks, and for your convenience, MC, Visa, Discover, and American Express. We also offer a payment plan through Care Credit. You may fill out an application and we will process it while you wait.

Upon our verification of your benefits, we will be happy to process your insurance benefits. However, you must understand that:

1) Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.

2) All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover.

3) Fees for services that are not covered, along with unpaid deductibles and co-payments are due at the time of treatment.

4) If your insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help speed things up.

5) If the insurance company does not pay in full within 45 days, we require you pay the balance due with cash, check, credit card, or Care Credit.

6) Returned checks and balances older than 45 days may be subject to additional collection fees and interest charges of 1.5% per month.

Please call our office at least 24 hours in advance if you need to reschedule an appointment. Please note that, unless canceled at least 24 hours in advance, you will be charged $50.00 per hour for missed appointments.

Again, thank you for choosing us as your dental care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Signature _____ Date _____

The Schoengold Group

Dear Valued Patient,

The American Dental Association endorses a program for the detection of periodontal disease. Our hygienist is a specialist in this area. Our examination procedure includes a process for early detection of gum disease. Early detection makes it easier to treat and control. Our hygienist will begin by examining your gums. She will gently use a ruler type instrument to measure any pockets that may exist between the tooth and gum, screen for inflammation and bleeding. If she discovers areas in the mouth which are tender or bleeding then this usually indicates less than healthy tissue.

Upon completion of the exam, the hygienist will put you in one of five ADA categories:

0 Healthy Mouth
1 Gingivitis
2 Early Periodontitis
3 Moderate Periodontitis
4 Advanced Periodontitis

Any classification other than a category 0 will take you out of the Healthy category and therefore a regular cleaning is not possible. This may change what your insurance covers.

Fortunately for our patients, Healthcare is constantly improving techniques and procedures in order to prevent and treat our patients properly and avoid surgery or possible tooth loss. Unfortunately, some insurance companies/employers are not keeping up with the improvements and are not covering certain procedures.

We, as your concerned providers understand this and will work with you as much as possible. Your oral health is important to us and we want to provide you with the absolute best treatment necessary.

Please feel free to discuss any questions or concerns about your insurance with the front office staff members, and any questions or concerns about your diagnosis with our hygienist.

Sincerely,

Dr. Jeffery Schoengold Signature:_____ Date:_____

The SCHOENGOLD GROUP

FAMILY • IMPLANTS • COSMETIC

White Plains + Riverdale

I grant permission to The Schoengold Group, on behalf of Dr. Jeffery Schoengold, to use photographs and or video taken of me for use on the The Schoengold Group web site (www.schoengolddentalgroup.com) or other electronic form or media, and to offer the photographs/video for use in other educational settings, with other health care professionals, or marketing/advertising (including website publication, Facebook post ect).

I waive any right to royalties or other compensation arising from or related to the use of the photographs/videos. I further understand that if the photographs, and videos are used in any publication or as part of a demonstration, my identifying information (first name only) could be used unless stated differently below.

I understand that I am free to address any specific questions regarding this release by submitting those questions in writing. If declining this consent please leave blank.

Please initial on option.

____I do not mind if my photographs are used in any of the above stated situations

___I only agree to have my teeth shown without any identifying features

Name _____

Parent/Guardian _____

Signature _____ Date _____

The Schoengold Group

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have read this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of read/receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)_____

Person we can speak to about your dental information: _____

_____