Your First Dental Visit at Dental Arts of Rockland:

Your first visit to our office will include a comprehensive oral evaluation:

- Introduction to our comfortable and friendly *Dental Spa*
- Review of Medical, Dental and Personal History
- X-rays (full mouth, panorex, bitewings)
- Oral Cancer Screening
- Initial Tooth Shade Selection
- Evaluation of Cosmetic Needs
- Dental Charting (evaluation of existing fillings, crowns, etc. and detection of new cavities)
- Periodontal (gum) Screening
- Comprehensive Exam by Dr. Steven Blechman
- Plaque, Bleeding and Tissue Description
- Periodontal Charting (if required, pocket depths, mobility of teeth, etc.)
- Personalized Oral Hygiene Instructions (toothbrush, floss, proxy brush, etc.)
- Check Fit and Clean Dental Appliances (partials, full dentures, night guards, etc.)
- *All your questions answered*

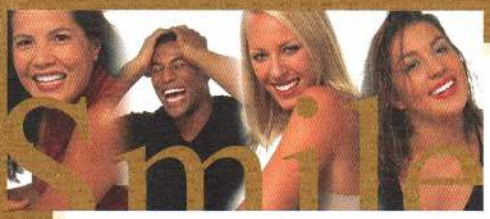
The following procedures may be performed at your second visit:

- Therapeutic Scaling and Plaque Removal
- Selective Polishing (removal of stains)
- Fluoride Treatment

Your Dentist and Hygienist will evaluate your periodontal (gum), dental and cosmetic condition and recommend a treatment plan. We encourage you to ask questions so that you can fully understand our recommendations.

We are very excited to meet you and create a happy, healthy dental relationship.

Thank You,
Your Dental Team at Dental Arts of Rockland



Welcome

We are pleased to welcome you to our practice.
Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ (Last Name / First Name / Middle Initial) Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

Cell Phone _____ Business Email _____

Primary Insurance

Person Responsible for Account _____ (Last Name / First Name / Middle Initial)

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Business Phone _____

Subscriber Employed by _____ Business Email _____

Insurance Company _____ Phone _____ Insurance Email _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Please complete both sides.

What would you like us to do today? _____

Are you in dental discomfort today? _____

Former Dentist _____ Address _____ Phone _____

Dentist's Email _____

Date of last dental care _____ Date of last X-rays _____

Check Y for yes or N for no if you have or have not had the following:

❑ Y ❑ N Bad breath
❑ Y ❑ N Bleeding gums
❑ Y ❑ N Clicking or popping jaw
❑ Y ❑ N Food collection between teeth
❑ Y ❑ N Grinding or clenching teeth
❑ Y ❑ N Loose teeth or broken fillings
❑ Y ❑ N Periodontal treatment
❑ Y ❑ N Sensitivity to cold
❑ Y ❑ N Sensitivity to hot
❑ Y ❑ N Sensitivity to sweets
❑ Y ❑ N Sensitivity when biting
❑ Y ❑ N Sores or growths in mouth

How often do you brush? _____ How often do you floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Medical History

Physician's name _____ Address _____ Phone _____

Physician's Email _____ Date of last visit _____

Have you had any serious illnesses or operations? ❑ Y ❑ N If yes, describe _____

Are you currently under physician care? ❑ Y ❑ N If yes, describe _____

Have you ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? ❑ Y ❑ N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ❑ Y ❑ N

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check Y for yes or N for no if you have or have not had any of the following:

❑ Y ❑ N AIDS/HIV Positive
❑ Y ❑ N Anaphylaxis
❑ Y ❑ N Anemia
❑ Y ❑ N Arthritis, Rheumatism
❑ Y ❑ N Artificial heart valves
❑ Y ❑ N Artificial joints
❑ Y ❑ N Asthma
❑ Y ❑ N Atopic (allergy prone)
❑ Y ❑ N Back problems
❑ Y ❑ N Blood disease
❑ Y ❑ N Cancer
❑ Y ❑ N Chemical dependency
❑ Y ❑ N Chemotherapy
❑ Y ❑ N Circulatory problems
❑ Y ❑ N Cortisone treatments
❑ Y ❑ N Cough, persistent
❑ Y ❑ N Cough up blood
❑ Y ❑ N Diabetes
❑ Y ❑ N Epilepsy
❑ Y ❑ N Fainting
❑ Y ❑ N Food allergies
❑ Y ❑ N Glaucoma
❑ Y ❑ N Headaches
❑ Y ❑ N Heart murmur
❑ Y ❑ N Heart problems
Describe _____
❑ Y ❑ N Hemophilia/Abnormal bleeding
❑ Y ❑ N Herpes
❑ Y ❑ N Hepatitis
❑ Y ❑ N High blood pressure
❑ Y ❑ N Jaw pain
❑ Y ❑ N Kidney disease or malfunction
❑ Y ❑ N Liver disease
❑ Y ❑ N Material allergies (**latex**, wool, metal, chemicals)
❑ Y ❑ N Mitral valve prolapse
❑ Y ❑ N Nervous problems
❑ Y ❑ N Pacemaker/Heart surgery
❑ Y ❑ N Psychiatric care
❑ Y ❑ N Rapid weight gain or loss
❑ Y ❑ N Radiation treatment
❑ Y ❑ N Respiratory disease
❑ Y ❑ N Rheumatic fever
❑ Y ❑ N Scarlet fever
❑ Y ❑ N Shingles
❑ Y ❑ N Shortness of breath
❑ Y ❑ N Skin rash
❑ Y ❑ N Spina Bifida
❑ Y ❑ N Stroke
❑ Y ❑ N Surgical implant
❑ Y ❑ N Swelling of feet or ankles
❑ Y ❑ N Thyroid disease or malfunction
❑ Y ❑ N Tobacco habit
❑ Y ❑ N Tonsillitis
❑ Y ❑ N Tuberculosis
❑ Y ❑ N Ulcer/Colitis
❑ Y ❑ N Venereal disease

List medications you are currently taking, if any:

_____

_____

List drug allergies, if any:

_____

_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

Dental Arts of Rockland
523 Route 303
Orangeburg, New York 10962
(845) 359-0407

Acknowledgement of Receipt of Dental Arts of Rockland, PLLC Notice of Patients Privacy

By my signature below, I hereby acknowledge receipt of this Notice of Privacy Practices, and I acknowledge that the Practice will use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting health care operations.

I have also been advised of my rights to obtain access to and control my Protected Health Information

_____ _____

Signature of Patient, Personal Representative, or Parent/Guardian Date

Financial Responsibility

I/We agree and personally guarantee, in consideration of services and materials provided by Dental Arts of Rockland, P.L.L.C., to be responsible for payment in full of the dental bill. I/We understand and agree to a rebilling fee in the amount of $15.00 if account balance is not paid in full within 30 days. In the event that this matter is turned over to an attorney for collection, I/We agree that jurisdiction for the said collection shall be Rockland County, New York, that I/We shall pay twenty-five percent (25%) attorney's fees, interest on the unpaid principle balance at the rate of eighteen percent (18%) per annum and all costs.

_____ _____

Signature of Patient, Personal Representative, or Parent/Guardian Date

Dental Arts of Rockland

Office Policies and Financial Agreement

We view our patient relationships with a deep sense of responsibility. A major part of that responsibility is to help our patients understand and plan for their oral health along with providing each patient with the highest quality of dental care. The following is a statement of Dental Arts of Rockland's Office Policies and Financial Agreement. We ask that you please read, agree to and sign the agreement before any treatment is rendered.

Regarding Insurance

For decades dental insurance has been an integral part of oral health planning; however, in the past few years it has become more difficult for the dental practice to deal with insurance companies. We are a third party to the contract and the insurance companies are not obligated to share your confidential policy information with us or required to send payment to us.

There are constant changes being made by your employer and insurance carriers to your coverage, deductibles and annual maximum. These changes are not being shared with us. Therefore, it is impossible for us to know exactly what your policy covers.

In order for us to maintain our high level of service to you the patient, we provide the courtesy of submitting the claim on your behalf and supporting you with maximizing your benefits. However, we are unable to carry your insurance balance for longer than 60 days. Policy coverage, changes and follow-up on unpaid claims is your responsibility. Please be prepared to show your insurance card at the time of the visit. _____ (Initial)

Payment Options

Your options include Cash, Check, MasterCard, Visa, Discover and American Express. We are pleased to offer you a choice of No Interest or Extended Payment Plans to qualified applicants through CareCredit, our financial partner. If you would like to make extended payments for services provided at our office, please ask Colleen for assistance in filling out an application form. _____ (Initial)

Cancellation Policy

If you are unable to keep an appointment, we ask that you kindly provide us with a minimum of **two** business days notice. All changes in your scheduled appointment **must** be handled during our regular business hours. This courtesy on your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist. _____ (Initial)

Office Hours:

Monday	10:00 AM – 7:00 PM
Tuesday	9:00 AM – 5:00 PM
Wednesday	8:30 AM – 5:00 PM
Thursday	9:00 AM – 6:00 PM
Friday	8:30 AM – 3:00 PM
Alternate Saturdays	8:00 AM – 1:00 PM

I have read, understand and agree to the above Office Policies and Financial Agreement.-

_____ _____

PATIENT SIGNATURE **DATE**

(PARENT/GUARANTOR signature if Patient is a MINOR

_____

CHILD'S NAME