BATTERY PARK
DENTAL GROUP

Battery Park Dental Group

375 South End Ave.
New York, NY 10280
Ph. (212) 619-4070 Fax: (212) 619-4098

www.BatteryParkDentalGroup.com

Please Complete and Return to Office

Name: Last First Middle

Address: Street, Apt. or P.O. Box # City State Zip code

Cell Phone: Home Phone: Work Phone:

Age: Yrs. Birth Date: Mo. Day Year Email Address ( ) Male ( )Married
( ) Female ( )Unmarried
( )Separated
( )Divorced

Social Security No: (if child, parents) **Whom may we thank for your referral?**

Occupation: Employer: How long employed?

Employer Address & Phone No:

Person responsible for bill: Age: Re lationship to Patient: ( ) Male Social Security No:
( ) Female
Driver's License No:

Address: Street, Apt. or P.O. Box # City State Zip code

Home Phone: Work Phone: Ext. Best Time to Call:

Occupation: Employer: How long Employed?

Employer Address & Phone No:

Insured Person's Full Name Date of Birth

Social Security Number Relati onship to Patient Work Phone

Insurance Company Name Group or Union Name Group or Local Numbers

Employer's Name Full Address of Employer

Is insured a patient? Yes No

CONSENT FOR SERVICES

Signature of Responsible Party Relationship Date

Credit Card Name & Number Expiration Date

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Medical History

1. Have you been under the care of a medical doctor during the past two years?.....❒Yes ❒No
   If yes: for what reason?_____
   Please provide the name, address, and telephone number of your physician.
   _____
   _____
9. Have you been a patient in the hospital during the past five years?.....❒Yes ❒No
   If yes: for what reason?_____
10. Have you taken any medicine or drugs during the past two years? If yes, please list:.....❒Yes ❒No
    _____
11. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspiring?
    ❒Yes ❒No If yes, please list:_____
    _____
11. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ❒Yes ❒No
    If yes, did you take any of the following: (circle if yes) Fen-Phen Pondimen Redux Other
    If yes to any of the above, did you have a medical exam for heart issues? ..... ❒Yes ❒No
12. Are you aware of having an allergic (or adverse) reaction to any substance or medication?..... ❒Yes ❒No
    If yes, please explain:_____
13. Have you lost or gained more than 10 pounds in the last year?.....❒Yes ❒No
14. Are you on a special diet?.....❒Yes ❒No
15. Check any of the following which apply in either past or present:

❒Heart (Surgery, Disease, Attack)	❒ Ulcers	❒ Hepatitis A B C (circle)
❒ Chest Pain	❒ Diabetes	❒ Venereal Disease
❒ Congenital Heart Disease	❒ Thyroid Problems	❒ A.I.D.S./H.I.V. Positive
❒ Heart Murmur	❒ Glaucoma	❒ Cold Sores / Fever Blisters
❒ High/Low Blood Pressure	❒ Contact Lenses	❒ Blood Transfusion
❒ Mitral Valve Prolapse	❒ Emphysema	❒ Hemophilia
❒ Artificial Heart Valve / Pacemaker	❒ Chronic Cough	❒ Sickle Cell Disease
❒ Rheumatic Fever	❒ Tuberculosis	❒ Bruise Early
❒ Arthritis/Rheumatism	❒ Asthma	❒ Liver Disease / Yellow Jaundice
❒ Cortisone Medicine	❒ Hay Fever / Allergies / Hives	❒ Neurological Disorders
❒ Swollen Ankles	❒ Latex Sensitivity	❒ Epilepsy or Seizures
❒ Stroke	❒ Sinus Trouble	❒ Fainting or Dizzy Spells
❒ Diet (Special / Restricted)	❒ Radiation Therapy	❒ Nervous / Anxious
❒ Artificial Joints (hip, knee, etc.)	❒ Chemotherapy	❒ Psychiatric / Psychological Care
❒ Kidney Trouble	❒ Tumors	

16. Do you have any disease, condition or problem not listed? If so, please list.....❒Yes ❒No
    _____
    _____
17. **Women:** Are you pregnant or think you could be pregnant? Yes _____Months No **Nursing?** ❒Yes ❒No
18. Do you use birth control prescriptions?.....❒Yes ❒No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Signature _____Date _____

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Dental History

1. What is the reason for your visit today?_____
   _____
2. Date of last dental visit_____Last dental cleaning_____Last full mouth X-Rays_____
3. What was done at your last dental visit? _____
   _____
4. Previous Dentist's Name_____
   Address/State/Zip_____
   Telephone_____
5. How often do you have dental examinations?_____
6. How often do you brush your teeth?_____ How often do you floss? _____
7. Have you ever used or are currently using topical fluoride? .....❒Yes ❒No
8. What other dental aids do you use? (Interplak, toothpick, etc.)_____
9. **Do you have any dental problems now?** .....❒Yes ❒No
   If yes, please describe._____
10. Check any of the following which apply in either past or present:

❒Hot or Cold Sensitivity
❒ Sweets Sensitivity
❒ Biting or Chewing Sensitivity
❒ Experience bad odors or bad tastes
❒ Frequent cold sores, blisters or other legions
❒ Bleeding gums
❒ Painful gums
❒ Experienced gum disease
❒ Have tooth loss
❒ Loose teeth
❒ Change in your bite
❒ Food catches between your teeth
❒ Clench or grind teeth while asleep
❒ Clench or grind teeth while awake
❒ Bite lips or cheek regularly
❒ Hold foreign objects with teeth (i.e. pencil)
❒ Mouth breathe while awake or asleep

❒ Snore or other sleeping disorders
❒ Use, smoke, chew tobacco
❒ Orthodontic treatment
❒ Oral Surgery
❒ Periodontal treatment
❒ Your teeth ground or bite adjusted
❒ Received a bite plate or mouth guard
❒ Clicking or popping of jaw
❒ Pain (joint, ear, side of face)
❒ Difficulty opening / closing mouth
❒ Difficulty chewing on either side of mouth
❒ Head, neck, or shoulder aches
❒ Sore muscles (neck, shoulder)
❒ A serious injury to the mouth or head?
If so, please describe, including cause_____
_____
❒ Experience tired jaws, especially in the morning

11. Are you satisfied with your teeth's appearance?..... .....❒Yes ❒No
12. Would you like to keep all of your teeth all of your life? ....❒Yes ❒No
13. Do you feel nervous about dental treatment? ....❒Yes ❒No
    If so, what is your biggest concern?_____
14. Have you ever had an upsetting dental experience? .....❒Yes ❒No
    Please describe. _____
15. Have you ever been told to take a pre-medication prior to dental treatment? .....❒Yes ❒No
    If so, what is your biggest concern?_____

Is there anything else you would like us to know? Please describe. _____
_____
_____

Patient / Guardian Signature _____Date _____

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Financial and Appointment Policy

We realize that every person's financial situation is different. For this reason we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile with respect to your budget.

DENTAL INSURANCE:

We are happy to file the forms necessary to see that you receive the full benefits of your coverage; however, we can make **no** guarantee of any ***estimated*** coverage. Please note that your dental policy is an agreement between you and the insurance company, and we ask that all patients be directly responsible for **all** charges. If you have any questions or discrepancies regarding your billing statement once you receive it, please contact us immediately. Otherwise, ***finance charges*** will incur **30 days** after your last treatment, and the interest will be calculated at **1.5%** per month (**18.5%** annually).

PAYMENT OPTIONS:

Payment of patient portions may be made with the following:

- **Major Credit Cards (Visa, MasterCard, American Express)**
- **Payment plan.** For patients who desire a monthly payment plan, we can make arrangements with you and customize a payment plan.

Statements will be mailed to all accounts monthly and are due upon receipt.

APPOINTMENT EXPECTATIONS and CANCELLATION POLICY:

We work very hard at treating our patients as unique individuals. We try to remain responsive to each person's needs. Unlike many dental practices where the dentist sees multiple patients at one time, we only see one patient at a time. When you book an appointment with us, you have our undivided attention for the length of that appointment.

Short notice cancellations or missed appointments increase our cost of providing dental care - costs that ultimately must be passed onto you, our patient. More importantly, missed appointments do not allow us the opportunity to offer the appointment time to other patients seeking our care. For these reasons, we ask that you read and agree to these expectations:

- Please respect our time and that of other patients by giving us a **minimum of two business days notice** to cancel or change an appointment.

- Patients with appointments which are missed or cancelled with less than 24 hours notice may incur a charge of $100.00 per appointment hour.

I agree that I have read this information and fully understand the financial and appointment policies for the office of Battery Park Dental Group. I authorize this office to release any necessary information to expedite insurance claims. I understand that I am solely responsible for all charges, regardless of insurance coverage. I agree to pay any collection fees or attorney expenses should it be necessary to refer this account to collections and I understand that any unpaid accounts will be reported to credit bureaus.

Patient's Signature or Responsible Party Date:

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OUR POLICIES

WELCOME to Battery Park Dental Group. It is our pleasure to have you as our patient. Our commitment is to provide you with the best dental care and to keep you informed of treatment recommendations and financial obligations.
The following are our office policies: **Please initial on each line that you have read and understand each policy:**

General Policy

_____**Payment is due at the time services are rendered**. We accept Cash, Mastercard,Visa, Discover,Amex & Care Credit
_____If you are having crowns, veneers, onlays, mouth guards or other work that must be sent to a dental lab, we require 50% deposit on the day the impressions are taken. At your final appointment to receive your crown, inlays, onlays etc., we will ask you for final payment in full.
_____Outstanding balances over 30 days are subject to 5% interest rate charge per month. Over 60 days, there will be a 10% interest rate charge, and accounts over 90 days will be sent to collections. Accounts over 30 days will incur a rebilling fee of $10.00. We work in partnership with Care Credit to finance monthly payments (approval process).
_____I hereby consent to the treatment indicated on my examination form, including the use of anesthetics, sedatives or x-rays as may be deemed necessary by the doctor.

Dental Insurance

_____With the exception of some preventative procedures such as cleanings and x-rays, your dental insurance company will not fully cover the cost of treatment. **You are responsible for the portion they do not cover, payable on the day you receive treatment.** Typical reimbursements by insurance companies range from 40% to 65%.
_____Some insurance companies will not reimburse you for white composite fillings. Instead, they reimburse you for less expensive silver/mercury fillings. If you have one of these plans, you may be responsible for up to 60% of the cost of these fillings.
_____Most dental plans have a deductible that you must pay each year, typically $50-$100. Usually the deductible does not apply to preventative work.
_____Since we will administer hundreds of employer benefit plans, we cannot know the details of every plan. It is the patient's responsibility to know the details of their coverage.
_____I hereby assign directly to Battery Park Dental Group, insurance benefits otherwise payable to me. I hereby authorize the release of any information relating to any claims. I understand I am financially responsible for charges not paid by this assignment.

Notice of Privacy Practices (HIPAA)

_____A laminated copy of our office Notice of Privacy Practices (HIPAA) is available in our office and attached to the New Patient paperwork which you are being asked to complete in our office. Upon your request, we will be happy to provide you with your own personal copy of our Privacy Practices. I have read and understand the Patient Privacy Rights information. _You may speak to the following concerning my account and any and all treatment until the time I rescind this permission:

Broken Appointments

_____Your appointment is time reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 48 hours notice. We do not accept cancellations left on the answering machine.
_____**Cancellations made with less than 48 hours notice, will be charged a $50.00 fee.**
We hope by presenting our policies to you in the beginning, we will avoid any misunderstandings and, therefore, have more time to dedicate to your dental care. If you have any questions regarding the above information or insurance coverage, please do not hesitate to ask...we are here to help!

I have read and agree to the payment and office policies at Battery Park Dental Group.

_____ _____

Patient signature Date