*45 North Station Plaza Ste 216 · Great Neck, NY 11021 · Dr. Eliot M. Heisler D.D.S. · 516-829-2001*

**Patient Information**

Patient Name: _____
Social Security Number: _____ - _____ - _____
Address:_____
City: _____
State:_____ Zip: _____
Sex: ☐ Male ☐ Female
Birth date: ____ / ____ / _____ Age: _____
Status: ☐ Single ☐ Married ☐ Other _____
Occupation:_____

**Dental Insurance** (Subscriber Information)

Subscriber Name:_____
Relationship to patient: _____
Birth date: ____ / ____ / _____
Social Security Number: _____ - _____ - _____
Employer: _____
Insurance Company: _____
Group Number: _____
Phone: (_____) - _____ - _____

**Contact Information**

Email: _____
Mobile: (_____) - _____ - _____
Home: (_____) - _____ - _____
Work: (_____) - _____ - _____
Other: (_____) - _____ - _____

Preferred contact method:
☐ Email ☐ Mobile ☐ Home ☐ Work ☐ Other

Best time to be reached:
☐ AM ☐ PM

**Emergency Contact**

Name: _____
Relationship to patient: _____
Number: (_____) - _____ - _____

**Dental History**

Reason for today's visit: _____
Former Dentist: _____
City/ State:_____
Date of last dental visit: ____ / ____ / _____
Date of last X-rays: ____ / ____ / _____

**Please check ( ✓) to indicate (YES) if you have had any of the following:**

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette, pipe, or cigar smoking
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection between teeth
- ☐ Foreign objects in mouth
- ☐ Gums swollen or tender
- ☐ Grinding teeth
- ☐ Jaw pain or tiredness
- ☐ Lip /cheek biting
- ☐ Loose teeth or broken fillings
- ☐ Mouth breathing
- ☐ Mouth pain
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in mouth
- ☐ Temporomandibular joint dysfunction (TMJ)
- ☐

## Patient Questionnaire

**Please read carefully and check ( ✓ ) the most suitable answer:**

How did you hear about our office?
□ Google □ Yelp □ Person _____ □ Other_____

Are you happy with your smile?
□ Yes □ No

Would you like to see your smile whiter?
□ Yes □ No

Are you interested in clear aligner therapy?
□ Yes □ No

How often do you brush?
□ Once Daily □ Twice Daily □ Three or More Times Daily

How much time do you spend brushing your teeth per session?
□ Less than 1 Minute □ 1-2 Minutes □ 3-5 Minutes □ More than 5 Minutes

What type of tooth brush do you use?
□ Manual-Soft □ Manual-Firm □ Electronic (Brand: _____)

How often do you floss?
□ Once Daily □ Twice Daily □ Three or More Times Daily □ I do not floss

## Medical History

Physician's Name: _____
Physician's Number: (_____) - _____ - _____
Date of last visit: ____ / ____ / _____
Pharmacy: _____
Phone: (_____) - _____ - _____

**Please check ( ✓ ) to indicate if (YES) you have had any of the following:**

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Asthma
- ☐ Back Problems
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Problems
- ☐ Hepatitis Type_____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Nervous Problems
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Scarlet Fever
- ☐ Special Diet/ Weight loss
- ☐ Stroke
- ☐ Swollen Feet or Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcer
- ☐ Venereal Disease

**Have you ever taken any of these medications?**

- ☐ Blood thinners
- ☐ Synthroid
- ☐ Lithium
- ☐ Bisphosphonate (Fosamax, Actonel, Atelvia, Didronel, Boniva)

**Have you had any complications following dental treatment?**

☐ Yes ☐ No

If yes, please describe:

_____
_____
_____

**Have you ever been hospitalized or have other health concerns?**

☐ Yes ☐ No

If yes, please describe:

_____
_____
_____

**Have you ever had or have been diagnosed with:**

- ☐ Artificial Heart Valves
- ☐ Artificial Joints, Screws, Pins, etc.
- ☐ Bleeding abnormally, with extractions or surgery
- ☐ Blood Disease
- ☐ Congenital Heart Lesions
- ☐ Heart Murmur
- ☐ Hernia Repair
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Rheumatic Fever

**Are you allergic to:**

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Ibuprofen
- ☐ Latex
- ☐ Local Anesthesia
- ☐ Metals (i.e. gold)
- ☐ Penicillin
- ☐ Other _____
- ☐ Other _____

**Please PRINT all medications now taking:**

_____
_____
_____

**Women ONLY:**

- ☐ Currently Pregnant /Nursing
  Due date: ___ / ___ / _____
- ☐ Taking birth control

# NOTICE OF PRIVACY PRACTICES

The privacy of your medical information is important to us. We understand that your medical and dental information is personal and we are committed to protecting it. This notice tells you about the ways we may use and share your medical/ dental information and about certain rights that you have.

USE AND DISCLOSURES OF YOUR MEDICAL/DENTAL INFORMATION:

Federal law provides that we may use your medical information (Protected Health Information) for treatment of you without further specific notice to you, or written authorization by you. We may use your information to obtain payment for our services, healthcare operations, quality assurance, financial services and claim management services.

We may use or disclose your medial information, without further notice to you, or specific authorization by you, where required by law, public health purposes, health oversight agency for oversight activities authorized by law, to report child abuse, in judicial and administrative proceedings, law enforcement purposes by law under 45 CFR|164.502, military authorities if you are a member of the armed forces.

We will continue to follow NYS law with respect to protecting information regarding HIV/AIDS. We may contact you my mail or phone, at your residence, business or other numbers provided by you to remind you of appointments or to provide information about treatment alternatives. Unless you instruct otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence.

RIGHTS THAT YOU HAVE:

You have the right to obtain copies of your medical information for a nominal fee. You have the right to request amendments to your medical information. Such requests must be in writing and must state the reason for the requested amendments. We will notify you as to whether we agree or disagree with the requested amendment.

OBLIGATIONS THAT WE HAVE:

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices. We are required to abide by the terms of this notice as long as it is currently in effect. We reserve the right to revise this notice and to make this new notice effective for all protected health information. The revised notice will be available in our office, copies will be posted, and available upon request. If you would like to indicate a violation of your privacy rights, you have the right to file a complaint with the Secretary of Health and Human Services of the United States. You may also file a complaint with us and should be directed to our Privacy Compliance Office. No retaliatory action will be taken against you for any complaint you make. I have received a paper copy of this notice.

Print Name: _____

Signature: _____

Date: _____

## TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient will be determined before treatment. As a condition of treatment by this office, I understand that financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangement, must be paid for at the time of services.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by insurance.

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I agree that in the event that either this office or 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 and agree to their consent.

Signature: _____ Date: _____

## CANCELLATION AND NO-SHOW POLICY

Office hours are by appointment and we do value your time. This office is a private practice dental office and not a dental "clinic". Appointment time is reserved for you alone. Where appropriate, we prefer to schedule longer appointments so we can complete as much needed dental treatment as possible during one appointment. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing your dental care. When you make an appointment, please be sure that you will be able to keep it.

Emergencies and unforeseen patient treatment problems may arise, causing schedule changes. Emergencies are unexpected and seem to come at the most inconvenient times. If you have a dental emergency that needs immediate attention, we will always offer to see you at once. We expect that other patients who might be slightly inconvenienced by this will understand of the situation.

Like many offices, this office does call to confirm your appointment. Please make a note of any dental appointments we have scheduled in a place where you will be easily reminded. If you cannot make an appointment as scheduled, please notify the office. There will be a charge of $75 for a broken appointment or cancellation with less than 24 hours notice for your appointment.

Signature: _____ Date: _____