WELCOME
TO ADVANCED DENTAL

Please take a few minutes to answer the following questions so we can better assist you with your health care needs

PATIENT INFORMATION

Date_____

Patient Name_____ Male ☐ Female ☐
(Last Name) (First Name)

Birth date _____/_____/_____ Patient Social Security# _____ - _____ - _____

Address _____ Apartment _____

City _____ State_____ZIP ___ ___ ___ ___ ___

Home Phone: _____	**Cell Phone:** _____	**e-mail:**

Referred by Doctor: _____ **Clinic Name:** _____

Clinic Address: _____

IN CASE OF EMERGENCY CONTACT:

Name _____Relationship _____

EMERGENCY PHONE NUMBER:

PRIMARY INSURANCE

Insurance Company _____

Subscriber _____ Subscriber ID# _____Group:_____
(Last Name) (First Name)

Relation to Patient _____ **Subscriber** Birth date _____/_____/_____**Subscriber** SS#_____

Subscriber Address _____ **Home Phone: ( )**

City _____ State_____ZIP ___ ___ ___ ___ ___

ADDITIONAL INSURANCE

Insurance Company _____

Subscriber _____ Subscriber ID# _____Group:_____

Relation to Patient _____ **Subscriber** Birth date _____/_____/_____**Subscriber** SS#_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to office Dr. _____ all insurance benefits, for any services provide me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for relates services. I agree to pay for all charges not covered by a third party payer. I Authorize a copy of this authorization to be used in place of the original. In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here. I expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each and every claim submitted.

Signature _____ Date _____

ADVANCED DENTAL SPECIALTY

CONSENT FORM USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

NAME: _____

ADDRESS: _____

TELEPHONE: (_____) _____/_____

EMAIL: _____

Section B: TO THE PATIENT PLEASE READ THE FOLLOWING STATEMENT CAREFULLY

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities and healthcare options.

NOTICE OF PRIVACY PRACTICES: You have the right to read our notice of privacy practice before you decide this consent. Our notice provides a description of our treatment payment activities and healthcare operation of the uses and disclosure we may make of your protected health information mater about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practice as describe in our notice of privacy practices. If we change our privacy practice we will issue a revised notice of privacy which will contain the change those changes may apply to any of your protected health information that we maintain.

You obtain a copy of our notice of privacy practices including any revisions of our notice at any time by contacting:

Contact person: Alice Cedeno

Address: 237 Willis Avenue Bronx NY, 10454

Phone: (718) 292-6209 / (718) 292-8988, fax :(917) 792-7979

Email: dds@bronxadvanced.com

RIGHT TO REVOKE: you will have the right to revoke this consent at any time by giving us writing notice of your revocation submitted to the contact person listed above. Please understand that by signing this consent payment activities and health care operations.

Signature: _____ **Date:** _____

If this consent is signed by a personal representative on behalf of the patient complete the following :

Personal representative's name: _____

Relation to the patient: _____

Section C: ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____ *, have received a copy of this offices*

Notice of Privacy Practices.

Signature: _____ **Date:** _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER SIGN IT

ADVANCED DENTAL SPECIALTY

Today's date: _____ /_____/_____

Patient Name: _____ D.O.B: _____/_____/_____

Address: _____apt# _____ State : _____ ZIP __ __ __ __ __

Please answer all questions correctly in order for the dentist to better plan for you treatment.
Please answer all questions by CIRCILING either YES or NO. CIRCULE SI o NO.

1.	*Are you under the care of a physician at the present time?*	*Yes*	*No*
	Esta bajo tratamiento de un medico?	*Si*	*No*
1.	*Are you presently taking medication?*	*Yes*	*No*
	Esta usted tomando medicinas recetadas ultimamente?	*Si*	*No*
2.	*Have you ever been told you have trouble with your heart?*	*Yes*	*No*
	Le han dicho alguna vez que padece del Corazon?	*Si*	*No*
3.	*Has a physician ever told you that you have High Blood Pressure?*	*Yes*	*No*
	Le ha dicho el medico alguna vez que tiene la Presion Alta?	*Si*	*No*
4.	*Do you have a heart murmur?*	*Yes*	*No*
	Tiene usted un soplo en el Corazon?	*Si*	*No*
5.	*Have you ever had or do you now have any infectious disease such us AIDS,Hepatitis,other?,*	*Yes*	*No*
	Tiene o ha tenido enfermedades infecciosas como SIDA, HEPATITIS O OTRAS	*Si*	*No*
6.	*Do you have allergies?*	*Yes*	*No*
	Tiene Allergias?	*Si*	*No*
7.	*Are you allergic to any drugs?*	*Yes*	*No*
	Allergico/a alguna medicina?	*Si*	*No*
8.	*Do you have any prosthetic joints or heart valves?*	*Yes*	*No*
	Tiene usted protesis en sus articulaciones o valvulas metalicas en el Corazon?	*Si*	*No*
9.	*Do you have diabetes?*	*Yes*	*No*
	Tiene Diabetis?	*No*	*No*
10.	*Do you have any bleeding problems? Prolonged bleeding following tooth extractions or cuts?*	*Yes*	*No*
	Sangra con Facilidad?	*No*	*No*
11.	*Have you had previous extractions with Local or General Anesthesia or Gas?*	*Yes*	*No*
	Ha Tenido extraciones anteriores con anesthesia general o local ,o gas?	*Si*	*No*
12.	*Have you ever had any trouble of any type when you had a tooth removed?*	*Yes*	*No*
	Ha tenido problemas anterior cuando ha tenido extracion ?	*Si*	*No*
13.	*Have you ever been treated with Cortisone or with Radiation (X-Ray)?*	*Yes*	*No*
	Ha estado tratado con cortisone o con radiacion?	*Si*	*No*
14.	*Have you had a venereal disease?*	*Yes*	*No*
	Ha tenido una enfermedad venerea?	*Si*	*No*
15.	*Have you ever had any operations or major surgery, serious illness, or been hospitalized for a long length of time?*	*Yes*	*No*
	Ha tenido alguna operacion o cirugia mayor, enfermedad grave o sido hospitalizado por un largo periodo?	*Si*	*No*
16.	*Are you PREGNANT?*	*Yes*	*No*
	Estas embarazada?	*Si*	*No*
17.	*Have you ever had tuberculosis, asthma or other lung troubles, liver, gall bladder, anemia, or epileptic convulsions?*	*Yes*	*No*
	Alguna vez has tenido tuberculosis,asma u otros problemas pulmonares,higado, vesicular biliar,anemia o convulsions epilepticas?		*No*
18.	*Are you smoker? Fuma?*	*Yes*	*No*

Patient Signature: _____