We are pleased you have selected us to provide dental care for you and your family.

Whom may we thank for referring you to our office? _____

Patient Information

Date _____ Patient's Name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street) _____ (Unit#) _____ (City) _____ (State) _____ (Zip)

Home Ph. # (_____) _____ Work Ph. # (_____) _____ Cell Ph. # (_____) _____ Marital Status _____

Soc. Sec. # _____ - _____ - _____ Drivers Lic. # _____ E-Mail: _____

Birthdate ___/___/___ Sex M F If patient is a minor, give parent's/guardian's name _____

Name of nearest relative not living with you _____ Relationship _____

If patient is a full-time student, fill in school name _____

School Address _____ Ph. # (___) _____

Emergency Contact _____ Ph. # (___) _____

Responsible Party Information

Name _____ (Last) _____ (First) _____ (Middle)

Soc. Sec. # _____ - _____ - _____ Birthdate _____/_____/_____ Relationship to Patient _____

Residence _____ (Street) _____ (Apt#) _____ (City) _____ (State) _____ (Zip)

Mailing Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

How long at this address _____ Home Ph.# (___) _____ Work Ph.# (___) _____ Fax# (___) _____

Previous Address (if less than 3 years) _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Spouse's Name _____

Soc. Sec. # _____ - _____ - _____ Birthdate _____/_____/_____ Work Ph.# (___) _____ Fax# (___) _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Insurance Information

Insured's Name _____ Insured's SS# _____ Insured's DOB _____ ID# _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ Ph. # (___) _____

Insured's Employer _____ Ph. # (___) _____

Do you have dual coverage? Yes ___ No ___ If yes: **Please complete the following secondary insurance information.**

Insured's Name _____ Insured's SS# _____ Insured's DOB _____ ID# _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ Ph. # (___) _____

Insured's Employer _____ Ph. # (___) _____

Dental Information

Do your gums bleed when you brush? Yes ___ No ___

Are your teeth sensitive to heat or cold? Yes ___ No ___ Pressure Yes ___ No ___ Sweets Yes ___ No ___

Do you grind or clench your teeth? Yes ___ No ___

Do you have any fear of dental work? Yes ___ No ___

Date of last dental visit _____ What was done at the time? _____

Former Dentist Name _____ City _____

How would you describe your current dental problem? _____

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

Medical Information

1. Are you having pain or discomfort at this time? YES NO
2. Have you been a patient in the hospital during the last two years? YES NO
3. Are you now taking any medication or drugs? YES NO

   If yes, please list: _____

4. A. Have you taken any medication or drugs during the last two years? YES NO

   B. Have you ever taken bisphosphonate medications for Osteoperosis or other bone loss related issues? YES NO
5. Have you been under the care of a medical doctor during the last two years? YES NO

   Physician's Name _____ Ph. # (___) _____

   Address _____
6. Are you sensitive or allergic to any medication or anesthetics? YES NO

   If yes, please list: _____
7. Indicate which of the following you have had or have at the present. Circle "yes or no" to each item.

Heart Failure	YES	NO	Osteoporosis	YES	NO	Hepatitis	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	If yes, which strain? (circle)	A	B C
Angina Pectoris	YES	NO	Ulcers	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	A.I.D.S.	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	H.I.V. Positive	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Cold Sores/Fever Blisters	YES	NO
Arteriosclerosis	YES	NO	Cancer	YES	NO	Blood Transfusion	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Anemia	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Sickle Cell Disease	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Bruise Easily	YES	NO
Rheumatic Fever	YES	NO	Hay Fever	YES	NO	Liver Disease	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Yellow Jaundice	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Epilepsy or Seizures	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Fainting or Dizzy Spells	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Nervousness	YES	NO
Stroke	YES	NO	Developmentally Disabled	YES	NO	Tumors	YES	NO
Allergy to Latex	YES	NO	Allergy to Metal (jewelry, etc.)	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO
						If yes, date _____		

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? YES NO
9. Do your ankles swell during the day? YES NO
10. Do you use more than two pillows to sleep? YES NO
11. Have you lost or gained more than ten pounds in the past year? YES NO
12. Do you ever wake up from sleep and feel short of breath? YES NO
13. Are you on a special diet? YES NO
14. Do you have or have you had any disease, condition, or problem not listed? YES NO

    If yes, please list: _____
15. Do you smoke? YES NO

FOR WOMEN ONLY:
Are you pregnant? Yes ___ What month? _____ No ___ Are you nursing? Yes ___ No ___ Are you taking birth control pills? 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 truthfully and to the best of my knowledge.

Patient/Guardian Signature _____ Date _____

Print Name _____

CONSENT:

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for the patient's treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 - 1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
6. I authorize the use of my social security number &/or insurance identification number to file my dental claim.

Patient _____ Date _____ Witness _____

Print Name _____

Guardian/Responsible Party if minor _____ Relationship to Patient _____

Print Name _____ Date _____

OFFICE USE: Reviewed by Dr. _____ Date _____

Putnam Bright Smile Dentistry, P.C.
2410 Route 6
Brewster, NY 10509
T: 845.279.7177 F: 845.278.2526

WELCOME TO OUR OFFICE!

Our team believes that patients treated by your office are the most important people in the world. We are delighted that you have chosen to join our family.

The enjoyment we experience in our association with our patients comes from a mutual understanding of the joint responsibility regarding complete care. We believe that sharing our thoughts with our patients helps form the bond that leads to a long-lasting relationship. A bright and healthy smile is, without questions, the most convincing form of communication.

TO BETTER SERVE YOU, PLEASE BE ADVISED OF THE FOLLOWING:

Our mission is to practice complete dental healthcare. Our goal is to provide each of our patients with the highest quality dental care in the most comfortable, gentle manner possible. We are committed to delivering your care with warmth and compassion and seek to prevent any dental problem in the future. Therefore, it is necessary for each patient to have comprehensive examination. The full treatment plan, associated fees and payment arrangements will be presented at that time.

Please be aware:

The treatment plan prescribed by your dentist is in his/her opinion the best treatment for your dental health. During the course of your treatment there may be unforeseen complications that will change the financial outcome the patient will be responsible for. These additional fees can include laboratory, office time and any extended dental treatment. Rest assured, you will be informed if any changes occur, in your existing treatment financial plan.

Please be confident that you will receive the best dental care available.

All fees are due and payable at the time of service, unless prior arrangements have been made.

I have read and fully understand all of the above information and agree to comply with office procedures.

X _____ Date_____
Signature of Responsible Party

THANK YOU FOR CHOOSING PUTNAM BRIGHT SMILE! WE KNOW YOU HAVE A CHOICE AND WE APPRECIATE YOUR CHOOSING OUR PRACTICE!

Putnam Bright Smile Dentistry, P.C.
2410 Route 6
Brewster, NY 10509
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Physician Update & Authorization to Release Healthcare Information

I, _____, authorize the exchange of records to or from my dental or
Print name
healthcare physician as well as to myself.

DOB: _____

Patient Signature: _____ Date: _____

Due to the strong links between gum disease and your overall health, it is important that your primary care physician is knowledgeable of your current periodontal condition. Please list your primary care physician below.

Physician Name: _____ Tel: _____
Address: _____, _____, _____
Street State Zip Code

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Print name

_____ _____
Signature Date

For Office Use **ONLY**

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

- o Individual refused to sign
- o Communication barrier prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (please specify)

_____
_____