MIDTOWN DENTISTRY™

Chart #: _____
FOR OFFICE USE ONLY

PATIENT INFORMATION Date: _____

Patient Name: _____
Last, First, MI (Preferred Name)

Social Security # _____ Birth Date ___/___/___ Driver's License # _____

Phone (Home) _____ (Work) _____ (Cel) _____

(E-mail) _____

What is your preferred method of communication? ❑ Home Phone ❑ Work Phone ❑ Cel ❑ E-mail

Address _____ Apartment # _____

City _____ State _____ Zip Code: _____

I prefer to be addressed on correspondence as _____ in person _____

Spouse's Name _____

MARITAL STATUS:

❑ Married ❑ Separated ❑ Single
❑ Divorced ❑ Widowed ❑ Engaged

Employer _____ Occupation _____

Bus. Phone _____

In case of Emergency, call _____ Cell _____

Phone _____ Address _____

(Name of close relative **NOT** living at your home address.)

Name _____

Phone _____ Address _____

Whom may we thank for referring you?

Name _____

Phone _____ Address _____

Did you visit our web site? **www.midtowndentistry.com** ❑ Yes ❑ No

DENTAL INSURANCE INFORMATION

Do you have dental insurance? ❑ Yes ❑ No

If yes: Name of Primary Carrier _____

Address _____

_____

Group Insurance No. _____ ID # _____

Is your treatment accident related? ❑ Yes ❑ No

If yes: Date of Accident _____

_____

Attorney handling the accident

_____
(name) (phone number)

Do you have medical insurance? ❑ Yes ❑ No

If yes: Name of Primary Carrier _____

Address _____

_____

Group Insurance No. _____ ID # _____

Signature _____ Date: _____

Do you have or have you ever had any of the following?

Y	N	Condition
❑	❑	Abnormal bleeding
❑	❑	Blood disorders
❑	❑	Anemia
❑	❑	Hypoglycemia
❑	❑	Sickle cell anemia
❑	❑	Hemophilia
❑	❑	Blood transfusion
❑	❑	Leukemia
❑	❑	High blood pressure
❑	❑	Low blood pressure
❑	❑	Fainting spells
❑	❑	Pacemaker
❑	❑	Mitral Valve Prolapse
❑	❑	Angina pectoris
❑	❑	Rheumatic fever
❑	❑	Artificial heart valve
❑	❑	Heart murmur
❑	❑	Bacterial endocarditis
❑	❑	Heart surgery
❑	❑	Congenital heart defect
❑	❑	Stroke
❑	❑	Other heart ailment
❑	❑	Lung disease
❑	❑	Difficulty breathing/shortness of breath
❑	❑	Allergies or Hay fever
❑	❑	Respiratory disease
❑	❑	Emphysema
❑	❑	Asthma
❑	❑	Tuberculosis
❑	❑	Sinus trouble
❑	❑	Intestinal disease
❑	❑	Stomach/GI disorders

Y	N	Condition
❑	❑	Ulcers
❑	❑	Colitis
❑	❑	Anorexia or Bulimia
❑	❑	Other eating disorder
❑	❑	Frequent headaches
❑	❑	Head Injury
❑	❑	Psychiatric problems/Nervous disorder
❑	❑	Epilepsy/Seizure
❑	❑	Alzheimer's disease
❑	❑	Arthritis
❑	❑	Rheumatism
❑	❑	Prosthetic joint replacement
❑	❑	Osteoporosis/Osteopenia
❑	❑	Tumor or growth
❑	❑	Cancer
❑	❑	Radiation treatment
❑	❑	Chemotherapy
❑	❑	Cosmetic surgery
❑	❑	Glaucoma
❑	❑	Kidney problems/Disease/Dialysis
❑	❑	Thyroid or Parathyroid disease
❑	❑	Diabetes - Insulin dependent
❑	❑	Diabetes - Oral medication
❑	❑	Hepatitis, Liver disease (A/B/C)
❑	❑	Venereal disease
❑	❑	Alcohol abuse
❑	❑	Drug abuse
❑	❑	AIDS/ HIV positive
❑	❑	Latex allergy
❑	❑	Fever blister
❑	❑	Xerostomia (dry mouth)
❑	❑	Burning tongue

MEDICATIONS

Are you sensitive or allergic to any medications?

Penicillin ❑ Yes ❑ No Sulfa Drugs ❑ Yes ❑ No

Tetracycline ❑ Yes ❑ No Codeine ❑ Yes ❑ No

Have you ever had penicillin? ❑ Yes ❑ No

Do you have any tattoos or body piercing? ❑ Yes ❑ No Location? _____

Does exposure to the sun cause you to break out? ❑ Yes ❑ No

Do you wear contact lenses? ❑ Yes ❑ No

Have you ever taken: ❑ Aredia ❑ Zometa ❑ Fosamax ❑ Actonel ❑ Boniva ❑ Fen-Phen Date: __/__/__

Please list any additional medications and reason for use:

Medication:	Dosage/Number of years	Prescribing doctor	Reason for use
Medication:	Dosage/Number of years	Prescribing doctor	Reason for use
Medication:	Dosage/Number of years	Prescribing doctor	Reason for use

DENTAL HISTORY

❑ General Dentist _____ Telephone _____

Address _____

Have you ever had a local anesthetic? (Lidocaine, etc.) ❑ Yes ❑ No

Have you ever had an unfavorable reaction to a local anesthetic? ❑ Yes ❑ No

Have you had any serious trouble associated with any previous dental treatment? ❑ Yes ❑ No

When was your last x-ray? _____

When was your last dental treatment? _____

Does dental treatment make you nervous? _____ ❑ Yes ❑ No

Have you ever had Nitrous Oxide Analgesia (gas) during dental treatment? ❑ Yes ❑ No

MEDICAL HISTORY

❑ Personal Physician _____ Telephone _____

Do you have any Biomedical or tissue implants such as:

	❑ Chin	❑ Breast	❑ Dental	❑ Knee	❑ Hip	❑ Heart Valve	❑ Craniofacial
Date:	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__

Do you use tobacco? ❑Yes ❑No ❑ Cigarette ❑ Pipe ❑ Cigar ❑ Chewing tobacco?

If so, how often? _____

Do you use alcohol? ❑ Yes ❑ No If so, how much? _____

Do you use drugs? ❑ Yes ❑ No If so, what type and how much? _____

Have you traveled abroad recently or experienced any health related symptoms after traveling abroad? ❑ Yes ❑ No

Have you spent any extended period of time in foreign countries? ❑ Yes ❑ No

Have you ever experienced diarrhea for extended periods of time? (2 to 3 months) ❑ Yes ❑ No

(Women) Are you pregnant? ❑ Yes ❑ No

(Women) Do you have any problems associated with your menstrual period? ❑ Yes ❑ No

(Women) Are you going through menopause now or have you in the past? ❑ Yes ❑ No

Please indicate stage: ❑Now ❑In past ❑Year started Completed: _____

Have you ever been treated by any of the following?

❑ Endodontist ❑ Periodontist ❑ Oral Surgeon ❑ Prosthodontist ❑ Orthodontist ❑ Otolaryngologist (Ear, Nose,Throat)

❑ Cardiologist ❑ Plastic Surgeon ❑ Endocrinologist ❑ Psychiatrist/Psychologist

Name	Address	Phone

CONSENT FOR INTERNET COMMUNICATIONS

I grant my permission to Jonathan Penchas, DMD, PA or Midtown Dentistry to upload and store confidential patient information – including account information, appointment information and clinical information – to the secured web site for Midtown Dentistry. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand Midtown Dentistry and myself are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that Midtown Dentistry is not liable for any charges, damages or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand Midtown Dentistry is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the Midtown Dentistry web site with my ID and password I also agree to immediately notify Midtown Dentistry of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand Midtown Dentistry will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Midtown Dentistry has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information.

I have requested that Midtown Dentistry communicate with myself or offices that pertain to my treatment. This communication will contain any necessary information electronically. By utilizing our practice's electronic e-mail system, we may send any communication that can be sent through the Internet to an e-mail address of a recipient. All electronic communications from our practice will be sent from our secured, non-encrypted e-mail server.
Acknowledgement to send e-mail in a non-encrypted format.

___ I request that you send necessary digital x-rays and information to a dental group/specialist/M.D. by e-mail for treatment pertaining to me, the patient.
___ I am responsible for providing the dental practice any updates to my e-mail address.
___ I am able to receive information electronically and store it securely away from any public computer.

E-mail Address _____

Signature _____ Date _____

CONSENT FOR DENTAL TREATMENT

I _____ hereby authorize any treatment necessary as related to the dental care of the patient whose name appears on this health history form and grant authority to administer such anesthetics, analgesics, sedatives and nitrous oxide sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I understand that there are possible adverse effects of the procedures, anesthetics and/ or drugs to be employed. I understand that dentistry is not an exact science and that reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that treatment may have complications. I accept the common risks and complications associated with dental treatment including teeth sensitivity, the need for root canal treatment, gingival/ gum problems and TMJ problems. I have had the opportunity to read this form and ask questions. I ask and give my consent to Doctors Penchas, Ward, Scheyer and Baez, other doctors, health care providers and staff in his office to treat me as their patient. My questions have been answered to my satisfaction. I certify this form has been fully explained to me, that I have read it or have had it read to me, and that I am not under the influence of any drugs and I understand its contents. I agree to be responsible for payment of all services rendered on my behalf.

Signature _____ Date _____

CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I understand there may be other problems associated with my oral condition that may be addressed at a later date. I understand that no warranty or guarantee has been made to me as to result, cure, or longevity of dental work. I give my permission to the Dentist and such associates, assistants, and other health care providers to make any/all changes and additions as necessary.

Signature _____ Date _____

PHOTOGRAPHS

I authorize Midtown Dentistry to take photographs, slide photos, and/or video tape of my teeth, jaws, and face. I understand that these photographic materials will be used as a record of my treatment, and may be used for educational purposes in lectures, presentations marketing materials, advertisements, and professional publications. I further understand that all reasonable attempts will be made to conceal my identity.

Signature _____ Date _____

DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the doctor of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

Signature _____ Date _____

PLEASE READ THE FOLLOWING STATEMENTS REGARDING NOTICE OF PRIVACY PRACTICE

TO THE PATIENT

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations. Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters 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 practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person Wanda Dowell

Telephone 713-807-9877 Fax: 713-807-0501

E-mail Address office@midtowndentistry.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE I, _____ , have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, 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 _____ Relationship to Patient _____

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

FINANCIAL 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 cannot guarantee any estimate of coverage. Midtown Dentistry does accept selected insurances on assignment. If we accept your dental insurance, we will file your insurance claim and notify you of your co-pay at the time of treatment. Insurance is never a guarantee of payment for the services rendered. If we do not accept your insurance, we will bill your primary insurance company as a COURTESY to you. You agree to pay for all services at the time services are rendered and the amount that the insurance determines to be eligible will be reimbursed to you personally by your insurance company. Finance charges will be assessed on accounts over 90 days past due.

Your signature is necessary for us to:

1. Process all insurance claims;
2. Ensure payment for services provided
3. Release medical information to insurance companies needed for the processing of your claims
4. Release information to other medical and dental providers, including laboratories, when necessary, for your treatment.

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to Dr. Jonathan Penchas. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

PAYMENTS

Check: A $25.00 fee will be assessed on all returned checks. Credit Cards: For your convenience we accept Master Card, Visa, Discover and American Express. On treatment involving laboratory fees: (crowns, bridges, dentures, and veneers) You may choose to pay 50% on the preparation date and the balance in two weeks. (See Treatment Plan Coordinator) I understand that payment is due when services are rendered, unless prior arrangements have been made.

CANCELLED/RESCHEDULED/MISSED APPOINTMENTS

We realize our patients have very busy schedules. We work hard to keep your wait to a minimum and find appointment times convenient for you and your family. However, all cancellations, rescheduled and missed appointments (without a twenty four (24) hour notice) are subject to 50% of the cost of the appointment. Please be considerate of our time, as we will be of yours. For all Cleaning / Hygiene appointments missed there will be a fee of $40.00 assessed to your account if not cancelled within twenty four (24) hours. I am aware that Jonathan Penchas DMD, PA or Midtown Dentistry is a Participating Provider with selected dental and no medical or health insurance company, including Medicare and Medicaid.

I am also aware and understand that I am fully responsible for all financial aspects of any services and treatment I receive. Even though Jonathan Penchas DMD, PA or Midtown Dentistry does not accept insurance for its services and treatment, Jonathan Penchas DMD, PA or Midtown Dentistry may submit a claim to my insurance company on my behalf at my request, in an effort to assist in obtaining insurance reimbursement directly to me. It is understood that even with this courtesy, it is my responsibility to pay for all financial aspects of any services and treatment I receive. Failure to provide at least 24 hours notice of appointment cancellation will result in a cancellation fee. (initial).

Signature _____ Date _____