EASTSIDE DENTAL MEDICINE
*The Center for Advanced Cosmetic and Implant Dentistry*

JYOTI P. SRIVASTAVA, MS, DDS
ROBERT G. CASTRACANE, DMD
595 Madison Ave., 27th Floor, New York, NY 10022
P: 212.758.9498 • P: 212.838.7676 • F: 212.838.3533
theteam@EastSideDentalMedicine.com • www.EastSideDentalMedicine.com

*Where skillful dentistry, health, beauty and luxury converge*

## Personal Information

First: _____ Middle: _____ Last: _____

Date of Birth: _____ Social Security: _____ Male: □ Female: □

Street: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Email: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Single: □ Married: □

How did you hear about EastSide Dental Medicine? _____

Whom may we thank for referring you? _____

I prefer to be contacted to confirm appointments by (check all that apply) Text: □ Email: □ Phone: □

Reason for today's visit: _____

Former Dentist: _____ City/State: _____

Date of last dental visit: _____ Last X-rays: _____

## Work Information □ Not Applicable

Occupation: _____

Patient Employer: _____

Employer Street: _____ Apt/Suite: _____

Employer City: _____ State: _____ Zip: _____

## Spouse Information □ Not Applicable

Spouse's Name: _____ Birthdate: _____

Spouse's Phone #: _____ Spouse's Employer: _____

## In Case of Emergency, Contact

Name: _____ Relationship: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

## Dental Insurance

Who is responsible for patient's account? _____ Relationship to Patient: _____

Insurance Co: _____ Group #: _____

Is patient covered by additional insurance? Yes □ No □

Subscriber's Name: _____ Relationship to Patient: _____

Birthdate: _____ Social Security: _____

Insurance Co: _____ Group #: _____

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## Dental History

PLEASE INDICATE "YES" OR "NO" IF YOU HAVE HAD ANY OF THE FOLLOWING:

| | | | |
|---|---|---|---|
| Bad Breath: | Yes □ No □ | Lip or cheek biting: | Yes □ No □ |
| Bleeding Gums: | Yes □ No □ | Loose teeth/broken fillings: | Yes □ No □ |
| Blisters on lips or mouth: | Yes □ No □ | Mouth breathing: | Yes □ No □ |
| Burning sensation on tongue: | Yes □ No □ | Mouth pain while brushing: | Yes □ No □ |
| Chew on one side of mouth: | Yes □ No □ | Pain around ear: | Yes □ No □ |
| Cigarette, pipe or cigar smoking: | Yes □ No □ | Periodontal treatment: | Yes □ No □ |
| Clicking or popping jaw: | Yes □ No □ | Orthodontic treatment: | Yes □ No □ |
| Dry mouth: | Yes □ No □ | Sensitivity to cold: | Yes □ No □ |
| Fingernail biting: | Yes □ No □ | Sensitivity to heat: | Yes □ No □ |
| Food collection between teeth: | Yes □ No □ | Sensitivity to sweets: | Yes □ No □ |
| Grinding teeth: | Yes □ No □ | Sensitivity when biting/chewing: | Yes □ No □ |
| Gums swollen or tender: | Yes □ No □ | Sores or growths in mouth: | Yes □ No □ |
| Jaw pain or tiredness: | Yes □ No □ | | |

How often do you floss? _____ How often do you brush? _____

## Oral Health

1. Describe your previous dental treatments: _____
3. Have your dental experiences been comfortable/positive? Please explain: _____
4. How do you maintain a healthy mouth? _____
5. How do you feel about the appearance of your smile? _____
6. If you could change anything about your smile, what would you change? _____

### Halitosis (Bad Breath) / Xerostomia (Dry Mouth)

7. Do you suffer from bad breath? Yes □ No □ If so, for how long?
8. Is the bad breath:
   □ Constant □ Sporadic □ In the morning □ At night
9. Do you smoke? Yes □ No □
10. Does your mouth often feel dry? Yes □ No □
11. Do you have any stomach issues? (Acid reflux, ulcers, etc.) Yes □ No □ If so, describe: _____
    _____
12. Would you like to discuss origin and treatment for Bad Breath and Dry Mouth? Yes □ No □

### Sleep Apnea

13. Do you wake up tired and feel you have not had enough sleep? Yes □ No □
14. How frequently do you experience or have you been told about snoring loud enough to disturb the sleep of others?
    □ Yes, everyday □ Occasionally □ Rarely/Never
15. How often have you been told you have 'pauses' in breathing or stop breathing during sleep?
    □ Never □ Rarely (Less than once a week) □ Occasionally (1-3 times a week) □ Frequently (More than 3 times a week)
16. Would you like to discuss origin and treatment for snoring and Sleep Apnea? Yes □ No □

## For Your Comfort

EastSide Dental Medicine would like to make your visit as comfortable as possible and ensure you are treated at the utmost level of care. Please indicate what we can provide you with to make your experience more comfortable.

- □ Protective Glasses
- □ IV Sedation [Fee]
- □ Nitrous Oxide (Laughing Gas) [Fee]
- □ Xanax
- □ TV
- □ Wi-Fi – To utilize your own equipment
- □ iPod and Wireless Noise Canceling Headphones
- □ Earplugs
- □ Pillow - For your neck and back support
- □ Blankets
- □ Beverage: Coffee, Tea (English Breakfast/Lemon/Green) and Water
- □ Hot Towel – After Treatment completion

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## MEDICAL HISTORY

PLEASE INDICATE "YES" OR "NO" IF YOU HAVE HAD ANY OF THE FOLLOWING:

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV: | Yes □ | No □ | Fainting or Dizziness: | Yes □ | No □ | Rheumatic Fever: | Yes □ | No □ |
| Anemia: | Yes □ | No □ | Glaucoma: | Yes □ | No □ | Scarlet Fever: | Yes □ | No □ |
| Arthritis: | Yes □ | No □ | Headaches: | Yes □ | No □ | Shortness of Breath: | Yes □ | No □ |
| Artificial Heart Valves: | Yes □ | No □ | Heart Murmur: | Yes □ | No □ | Sinus Problems: | Yes □ | No □ |
| Artificial Joints: | Yes □ | No □ | Heart Problems: | Yes □ | No □ | Skin Rash: | Yes □ | No □ |
| Asthma: | Yes □ | No □ | Hepatitis Type: | Yes □ | No □ | Special Diet: | Yes □ | No □ |
| Back Problems: | Yes □ | No □ | Herpes: | Yes □ | No □ | Stroke: | Yes □ | No □ |
| Abnormally Bleeding | Yes □ | No □ | High Blood Pressure: | Yes □ | No □ | Swollen Feet or Ankles: | Yes □ | No □ |
| Blood Disease: | Yes □ | No □ | Jaundice: | Yes □ | No □ | Swollen Neck Glands: | Yes □ | No □ |
| Cancer: | Yes □ | No □ | Jaw Pain: | Yes □ | No □ | Thyroid Problems: | Yes □ | No □ |
| Chemical Dependency: | Yes □ | No □ | Kidney Disease: | Yes □ | No □ | Tonsillitis: | Yes □ | No □ |
| Chemotherapy: | Yes □ | No □ | Liver Disease: | Yes □ | No □ | Tuberculosis: | Yes □ | No □ |
| Circulatory Problems: | Yes □ | No □ | Low Blood Pressure: | Yes □ | No □ | Tumor or Growth | | |
| Congenital Heart Lesions: | Yes □ | No □ | Mitral Valve Prolapse: | Yes □ | No □ | on Head or Neck: | Yes □ | No □ |
| Cortisone Treatments: | Yes □ | No □ | Nervous Disorders: | Yes □ | No □ | Ulcer: | Yes □ | No □ |
| Cough Persistent or Bloody | Yes □ | No □ | Pacemaker: | Yes □ | No □ | Unexplained | | |
| Diabetes: | Yes □ | No □ | Psychiatric Care: | Yes □ | No □ | Weight Loss: | Yes □ | No □ |
| Emphysema: | Yes □ | No □ | Radiation Treatment: | Yes □ | No □ | | | |
| Epilepsy: | Yes □ | No □ | Respiratory Disease: | Yes □ | No □ | | | |

Do you wear contact lenses? Yes □ No □
Taking birth control pills? Yes □ No □
Women: Are you pregnant? Yes □ No □ Due Date: _____ Are you nursing? Yes □ No □

## MEDICATIONS

Please list all medications you are currently taking:_____
Pharmacy Name:_____ Phone:_____

## ALLERGIES

Aspirin: □ Codeine: □ Latex: □ Penicillin: □
Barbiturates (Sleeping Pills): □ Iodine: □ Local Anesthetic: □ Sulfa: □
Other: □ _____

Have you ever had any complications following dental treatment? Yes □ No □
If so describe:_____
Do you require any antibiotic pre-medication prior to dental treatment? Yes □ No □
If so describe:_____
Have you been admitted to a hospital or needed emergency care during the past two years? Yes □ No □
If so describe:_____
Are you currently under the care of a physician? Yes □ No □
Name of physician:_____ Phone:_____
Do you have any health problems that need further clarification? Yes □ No □
To the best of my knowledge, all preceding answers and information are true and correct. If any of the above changes I will inform the doctors at my next appointment.

**Signature of Patient, Parent, Guardian or Personal Representative** **Date**

_____ _____

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# PAYMENT POLICY

Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important health service.

For your first visit with us, a full payment for treatment rendered is expected. Insurance is not accepted as a form of payment, however, we will submit all the necessary paperwork for your reimbursement. For visits thereafter, we will happily arrange your financial obligations with the following options:

## Payment in Full

Bookkeeping courtesy of 5% will be given for direct payment in full by cash or check at the start of treatment, for treatment totaling $3,000 or more.

## Extended payment Options

### PAYMENT BY APPOINTMENT

Make payment for treatment completed per each appointment.

### OFFICE PAYMENT PLAN

We require an initial payment of 1/3 or 33% for all the major treatment involving lab work (crowns, bridges, veneers, implants, complete or partial dentures, etc) is expected at the start of treatment. The remaining balance must be paid by the impression visit.

### INTEREST FREE OPTION (Health Care Financing Program)

No interest charges if paid within a specific time period of 12 months for the treatment plans of $1,000 or more. (Please note the required minimum monthly payment will be based on the terms of your loan.) Fast, confidential service by phone, (800)204-3332, or online at www.dentalfeeplan.com.

## WE ACCEPT THE FOLLOWING MODES OF PAYMENT

Cash, check or the following credit cards: Visa, American Express, MasterCard, and Discover.

## CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies for the patient. However, this office cannot render services on the assumption that our charges will be paid by an insurance company.

## ASSIGNMENT AND RELEASE:

I certify that I, and/or my dependent(s), have insurance coverage with:

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Compan(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

I have read the above conditions of treatment and payment and agree to their content.

| Signature of Patient, Parent, Guardian | Relationship to Patient | Date |
|---|---|---|
| Signature of guarantor of payment | Relationship to Patient | Date |

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# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on 4/28/2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request copy of our Privacy Notice at any time by contacting our Privacy Officer, Information on contacting us can be found at the end of this Notice.

**TYPICAL USES AND DISCLOSURES OF THE HEALTH INFORMATION**
We will keep your health information confidential, using it only for the following purposes:

**Treatment:** We may use your health information to provide you with our professional services. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

**Disclosure:** We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

**Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

**Required by Law:** We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

**Marketing Health-Related Services:** We will not use our health information for marketing purposes unless we have your written authorization to do so.

**National Security:** If the health information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

**HIPPA Notice of Privacy Practices**
**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**Notice to Patient:**
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.
I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

| Print Name | Signature of Patient, Parent, Guardian | Date: |
|---|---|---|