

A NEW SMILE .
Patient Information and Consent
 Suzanne Abergel-Nahon D.D.S, P.A.



Chart #: _____ For Office Use Only

Patient Information			
Patient Name:	_____ <small style="display: inline-block; width: 20%; text-align: center;">Last</small> <small style="display: inline-block; width: 20%; text-align: center;">First</small> <small style="display: inline-block; width: 20%; text-align: center;">MI</small> <small style="display: inline-block; width: 35%; text-align: right;">(Preferred Name)</small>	Date:	_____
Social Security #:	_____	Birth Date:	_____
Gender:	_____		
Phone (Home):	_____	(Work):	_____
Ext:	_____	Occupation:	_____
Cell #:	_____	Emergency Phone:	_____
E-mail address:	_____		
Address:	_____		
	Street		Apartment #
	City	State	Zip Code

Health Information

• Reason for the visit: _____

Dental History

- Are you experiencing any pain or discomfort in your mouth at this time? Yes No
 If yes, explain: _____
- Do your gums bleed after brushing? Yes No
- Have you ever had gumboils or abscesses? Yes No
- Have you ever been referred to a Periodontist (gum disease specialist)? Yes No
- Have you ever had any teeth extracted because of periodontal disease (Pyorrhea)? Yes No
 If yes, when? _____
- Have you previously been informed of gum trouble (Pyorrhea or Trench Mouth)? Yes No
 If yes, when? _____
- Do you have any teeth, which have shifted position recently? Yes No
- Do you put foreign objects between your teeth? Pipe, hairpins, musical instruments, etc. Yes No
 If yes, explain: _____
- Are you aware of any loose teeth? Yes No
- Are you aware of any high or rough teeth or fillings? Yes No
- Do you frequently clench or grind you teeth when tired, tense, angry or asleep? Yes No
- Do you bite your lips, check or tongue? Yes No
- Do you form calculus (tartar) on your teeth rapidly? Yes No
- Do you chew gum, use lifesavers, mints or Roloids almost daily? Yes No
- Do you or have you ever had a bad taste in your mouth? Yes No
- Are you aware of offensive breath? Yes No

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- When you wake up in the morning is your mouth dry? Yes No
- Have you ever had your teeth straightened (Orthodontic Treatment)? Yes No
- Have you ever had any complications following dental treatment? Yes No
If yes, explain: _____
- Last time your teeth were cleaned: _____
- How many times do you brush your teeth per day? _____
- Are you happy with the appearance of your teeth? Yes No
If not, why? _____

Medical History

Have you ever had any of the following? Please check those that apply:

	Yes	No		Yes	No
Abnormal Bleeding			Lupus		
Anemia			Nervous Disorders		
Arthritis			Neurological Disorders		
Artificial Joints			Osteoporosis		
Asthma			Pacemaker		
Bladder or Kidney Involvement			Pain over the heart		
Blood Disease			Pain under the breast bone		
Blood Transfusion (if yes, date)			Persistent cough		
Burning Tongue			Persistent swollen glands in neck		
Cancer			Pneumonia		
Cold Sores (lip)			Radiation Treatment		
Congenital Heart lesion			Recurrent infection (if yes, indicate type)		
Diabetes			Respiratory Problems		
Dizziness			Rheumatic Fever		
Epilepsy			Severe headaches/migraines		
Excessive bleeding			Severe or rapid weight loss		
Excessive urination			Shortness of breath		
Fainting			Sinus Problems		
Glaucoma			Skin condition or rash		
Hay Fever			Sleep Disorders		
Head Injuries			Sore or ulcers in the mouth		
Heart Disease			Stomach Problem		
Heart Murmur			Stroke		
Hemophilia			Thyroid Problems		
Hepatitis			Tuberculosis		
High Blood Pressure			Tumors		
HIV infection or AIDS			Ulcers		
Jaundice			Venereal Disease		
Kidney Problems			Warts		
Liver Disease			Other		
Low Blood Pressure					

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Do you have any cardiovascular conditions?

If yes please specify below:

	Yes	No		Yes	No
Angina			Heart Murmur		
Arteriosclerosis			High Blood Pressure		
Artificial heart valves			Low Blood Pressure		
Congenital heart defects			Mitral valve prolapse		
Congestive heart failure			Pacemaker		
Coronary artery disease			Rheumatic Heart		
Damaged heart valves			Disease/Rheumatic Fever		
Heart attack					

Other:

Do you have respiratory problems?

If yes please specify below:

	Yes	No		Yes	No
Emphysema			Bronchitis		
Pneumonia			Persistent cough		

Other:

Do you have any Allergies?

If yes please specify below:

	Yes	No		Yes	No
Local anesthesia			Codeine or other narcotics		
Penicillin			Latex		
Other antibiotics			Iodine		
Barbiturates, sedatives or sleeping pills			Food		
Sulfa drugs			Metals		

Other:

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain:

• Are you now under the care of a physician? Yes No

If yes, please explain:

• Name of Physician: _____ Phone: _____

• Are you taking or have you recently taken any medicine (including non-prescription)? Yes (list below) No

Prescribed:

Over the counter:

Vitamins, natural or diet supplements:

• Are you taking or have you taken any diet drugs such Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)? Yes No

• Do you or did you ever take Fosamax or any other medication for osteoporosis? Yes No

• Do you drink alcoholic beverages? Yes No

Suzanne Abergel-Nahon D.D.S, P.A.
14050 S.W. 84th St.
Miami, FL 33183

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND
CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**I HAVE THE RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES BEFORE
SIGNING THIS CONSENT. I HAVE BEEN GIVEN THE OPPORTUNITY TO READ AND
RECEIVE A COPY OF SUZANNE ABERGEL-NAHON D.D.S PA NOTICE OF PRIVACY
PRACTICES.**

With my consent **Suzanne Abergel-Nahon D.D.S, P.A.** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **Suzanne Abergel-Nahon D.D.S, P.A.** Notice of Privacy Practices for a more complete description of such uses and disclosures.

Suzanne Abergel-Nahon D.D.S, P.A. reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer at **Suzanne Abergel-Nahon D.D.S, P.A. 14050 S.W. 84th Street, Miami, FL 33183.**

With my consent **Suzanne Abergel-Nahon D.D.S, P.A.** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent **Suzanne Abergel-Nahon D.D.S, P.A.** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

With my consent **Suzanne Abergel-Nahon D.D.S, P.A.** may disclose my information for purposes of internal staff training or for external educational uses. For example, the doctor may use my health information as part of an academic seminar to demonstrate treatment techniques.

With my consent **Suzanne Abergel-Nahon D.D.S, P.A.** may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Suzanne Abergel-Nahon D.D.S, P.A.** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Suzanne Abergel-Nahon D.D.S, P.A.** use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Suzanne Abergel-Nahon D.D.S, P.A.** may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Print Name of Patient or Legal Guardian

Date

Good faith attempts to obtain the signature from the patient; describe the reason why patient did not sign the form:

Signature of the Staff Member

Name of the Staff Member

Date

Insurance Information and Consent

Suzanne Abergel-Nahon D.D.S, P.A.

Chart #: _____
For Office Use Only

Patient Information

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

Social Security #: _____ Birth Date: _____

Address: _____ Apartment # _____
Street
City State Zip Code

Insurance Information

(Please present your insurance card and picture identification to the receptionist)

Primary

Insurance Plan Name: _____

ID #: _____ Group #: _____

Patient's relationship to insured: Self Child Other _____

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Name of insured (if other than patient): _____
Last First MI

Insured's Birth Date: _____

Insured's Address: _____
Street City State Zip Code

Secondary

Insurance Plan Name: _____

ID #: _____ Group #: _____

Patient's relationship to be insured: Self Spouse Child Other _____

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Name of Insured (if other than patient): _____
Last First MI

Insured's Birth Date: _____

Insured's Address: _____
Street City State Zip Code

Insurance Information and Consent

Suzanne Abergel-Nahon D.D.S, P.A.

Acknowledgement and Consent

The goal of Suzanne Abergel-Nahon D.D.S, P.A. is to provide patients with the best dental care. If a patient has dental insurance, the office staff will assist him/her in utilizing the benefits provided under the policy. In order to achieve these goals, it is important that the patient /responsible party understand and agree to the following conditions of treatment and payment.

1. The insurance information I have provided is correct and I authorize Suzanne Abergel-Nahon D.D.S, P.A. to seek reimbursement from my insurance company.
2. I understand that after examination, the doctor will recommend treatment based upon what he/she feels is in the interest of my health, well being, or appearance. The treatment may or may not be covered by my insurance. Possible reasons that insurance will not cover treatment include:
 - a. The procedure or service is not approved for reimbursement by the policy.
 - b. The patient has exceeded the benefits allowable under the plan.
 - c. The treatment is considered cosmetic in nature
 - d. The required referral or pre-authorization was not obtained.
3. I understand that even if treatment is covered by my insurance, my plan may have a deductible or require co-payments or coinsurance and I am personally responsible for the portion of the fee not paid by my insurance.
4. I understand that I am personally responsible for payment of fees for all services. Any reimbursement provided by my insurance company will be credited to my account.
5. I agree that I will make payment for all fees at the time of service unless prior arrangements have been agreed upon in writing

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

Signature of patient, parent or guardian

Date: _____ Relationship to Patient: _____