



A New Smile Dental Center

Patient Information

Today's Date: _____

Name: _____ Birthdate: _____ SS# _____

Address: _____ City: _____ St _____ Zip _____

H Phone: _____ Cell Phone: _____ Work # _____

E-mail _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone: _____

Reason for your visit today? _____

Responsible Party

Name: _____ SS#: _____

Birthdate: _____

Relationship: _____

Address: _____ City: _____

ST: _____ Zip: _____

Insurance Information

Name of Insured _____ Relationship to patient _____

Birthdate _____ SS# _____

Name of Employer _____ Work # _____

Insurance Company _____ Group # _____

A fee of \$25 will be charged for cancelled appts. Without 24 hour notice.

Please sign X _____

Patient Medical History

1. Are you under medical treatment? Yes [] No []
2. Have you ever been hospitalized Yes [] No []
For any operation or serious illness?
If yes, explain _____
3. Are you taking any medication? Yes [] No []
If yes what medications _____
4. Do you use tobacco? Yes [] No []
5. Have you taken Fen- Phen/Redux? Yes [] No []
6. Do you use controlled substances? Yes [] No []

8. Are you allergic to or had any reaction to the following?

Local Anesthetics (e.g. Novocaine) Yes [] No []

- Penicillin or any other Antibiotic Yes [] No []
Sulfa Drugs Yes [] No []
Barbiturates Yes [] No []
Sedatives Yes [] No []
Iodine Yes [] No []
Aspirin Yes [] No []
Any Metals (nickel, metal, ect) Yes [] No []
Latex Rubber Yes [] No []

7. Do you have or have you had any of the following?

- | | | | | | |
|------------------------|----------------|-----------------------|----------------|------------------------|----------------|
| - High Blood Pressure | Yes [] No [] | - Heart Disease | Yes [] No [] | - Stroke | Yes [] No [] |
| - Heart Attack | Yes [] No [] | - Cardiac Pacemaker | Yes [] No [] | - Hay Fever | Yes [] No [] |
| - Rheumatic Fever | Yes [] No [] | - Heart Murmur | Yes [] No [] | - Tuberculosis | Yes [] No [] |
| - Seizures | Yes [] No [] | - Angina | Yes [] No [] | - Radiation | Yes [] No [] |
| - Asthma | Yes [] No [] | - Anemia | Yes [] No [] | - Glaucoma | Yes [] No [] |
| - Low Blood Pressure | Yes [] No [] | - Emphysema | Yes [] No [] | - Recent Weight Loss | Yes [] No [] |
| - Epilepsy/ Convulsion | Yes [] No [] | - Cancer | Yes [] No [] | - Liver Disease | Yes [] No [] |
| - Leukemia | Yes [] No [] | - Arthritis | Yes [] No [] | - Heart Trouble | Yes [] No [] |
| - Diabetes | Yes [] No [] | - Joint Replacement | Yes [] No [] | - Respiratory Problem | Yes [] No [] |
| - Kidney Disease | Yes [] No [] | - Jaundice/ Hepatitis | Yes [] No [] | - Mitral Valve Prolaps | Yes [] No [] |
| - Aids or HIV | Yes [] No [] | - Sexual disease | Yes [] No [] | - Other | Yes [] No [] |
| - Thyroid Problem | Yes [] No [] | - Chest Pain | Yes [] No [] | | |

Patient Dental History

Name of Previous Dentist and Location: _____ Date of last exam _____

- | | |
|--|--|
| 1. Do your gums bleed while brushing or flossing? Yes [] No [] | 7. Do you have frequent headaches? Yes [] No [] |
| 2. Are your teeth sensitive to hot or cold liquids? Yes [] No [] | 8. Do you grind your teeth? Yes [] No [] |
| 3. Do you feel any pain in your mouth? Yes [] No [] | 9. Do you bite your lips or cheeks? Yes [] No [] |
| 4. Do you have any sores or lumps in mouth? Yes [] No [] | 10. Have you had difficult extractions? Yes [] No [] |
| 5. Have you're had head, neck or jaw injuries? Yes [] No [] | 11. Have you had prolonged bleeding? Yes [] No [] |
| 6. Have you experienced any of the following problems in your jaw? | 12. Have you had ortho treatment? Yes [] No [] |
| Clicking yes [] No [] | 13. Do you wear dentures or partials? Yes [] No [] |
| Pain Yes [] No [] | 14. Do you like your smile? Yes [] No [] |
| Difficulty opening or closing Yes [] No [] | |
| Difficulty in chewing Yes [] No [] | |

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X _____ Date _____ X _____ Date _____
Signature of patient Doctor's Signature

A New Smile Dental Center

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.** to 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.

Please turn over -->

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

*A New Smile Dental Center
14050 SW 84 St Suite 103
Miami, Fl 33183*

Assignment and Instruction For Direct Payment to Doctor

Patient: _____
Employer: _____
Claim Group: _____
SS# / ID#: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

A New Smile Dental Center
14050 SW 84 St Suite 103
Miami, Fl 33183

OR

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

C/O Suzanne Abergel-Nahon, DDS
To the Same as above

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall I be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

X _____
Signature of Policyholder

Date

Simple Agreement Form

Patient authorizes the Doctor to deposit checks received on Patient's account when made out to the Patient.

X _____
Signature of Policyholder

Date