

HOLBROOK PROFESSIONAL CENTER
900 MAIN STREET, SUITE 104
HOLBROOK, NEW YORK 11741

TELEPHONE 981-5600

RICHARD H. CHANIN, D.D.S.
GREG B. CINSKI, D.M.D.



COSMETIC & FAMILY DENTISTRY
www.holbrooksmiles.com

PATIENT REGISTRATION

Today's Date _____

Name _____ Preferred _____

Address _____

City _____ State _____ Zip _____

Telephone: Home _____ Cell _____ Work _____ Ext. _____

Birth Date _____ Social Security # _____ Email _____

Sex: Male Female Martial Status: Single Married Separated Divorced Widowed

How did you hear about our practice? _____

TO GET TO KNOW YOU BETTER PLEASE LIST ANY HOBBIES, INTERESTS, OR SPORTS

If a child or student give school name and grade level _____

Purpose of visit _____

Employer's Name _____

Employer's Address _____

City _____ State _____ Zip _____

Present position _____ How long held? _____

Who will be responsible for this account? Self () Spouse () Parent ()
(If you checked "Self" please skip this section and continue with insurance information)

Person responsible for this account, other than above patient:

Name _____ Birth Date _____

Street Address _____

City _____ State _____ Zip _____

Home Phone: () _____ Work Phone () _____

Employer's Name _____

Employer's Address _____ City _____ State _____ Zip _____

Social Security # _____

HOLBROOK PROFESSIONAL CENTER
900 MAIN STREET, SUITE 104
HOLBROOK, NEW YORK 11741

TELEPHONE 981-5600

RICHARD H. CHANIN, D.D.S.
GREG B. CINSKI, D.M.D.

COSMETIC & FAMILY DENTISTRY
www.holbrooksmiles.com



For Patients covered by Dental Insurance:

Subscriber's Name _____ Birth Date _____
Employer's Name _____
Employer's Address _____
City _____ State _____ Zip _____
Social Security # _____
Insurance Company _____

Relationship to Patient () Self () Spouse () Parent or Guardian

Is the patient covered by another dental insurance?

If yes, please fill out the next section.

Secondary Dental Insurance

Subscriber's Name _____ Birth Date _____
Employer's Name _____
Employer's Address _____
City _____ State _____ Zip _____
Social Security # _____
Insurance Company _____

Relationship to Patient () Self () Spouse () Parent or Guardian

To better acquaint ourselves with your family please list other family members - Thank You

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____

APPOINTMENTS: This time is reserved exclusively for you. **24 hours** notice is appreciated if you are unable to keep your appointment. A minimum charge will be made for a broken or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of office overhead which still has to be paid whether you are present or not. In addition, other patients cannot be scheduled because WE HAVE RESERVED THE TIME FOR YOU!

HOLBROOK PROFESSIONAL CENTER
900 MAIN STREET, SUITE 104
HOLBROOK, NEW YORK 11741

TELEPHONE 981-5600

RICHARD H. CHANIN, D.D.S.
GREG B. CINSKI, D.M.D.

COSMETIC & FAMILY DENTISTRY
www.holbrooksmiles.com



MEDICAL AND DENTAL HISTORY

TODAY'S DATE _____

PATIENT'S NAME _____

DATE OF BIRTH _____

ARE YOU HAVNG PAIN AND DISCOMFORT AT THIS TIME?

Circle
Yes No

HAVE YOU EVER HAD A BAD DENTAL EXPERIENCE?

Yes No

WHEN WAS YOUR LAST DENTAL EXAM?

WHEN & WHERE WERE YOUR LAST DENTAL X-RAYS?

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING?

INDICATE WITH A (✓)

- | | |
|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> Gums That Bleed | <input type="checkbox"/> Gums That Are Red, Swollen or Tender |
| <input type="checkbox"/> Gums That Have Pulled Away From Your Teeth | <input type="checkbox"/> Teeth That Are Loose |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Change in the Way Your Teeth Fit Together |
| <input type="checkbox"/> Teeth That Are Sensitive to Cold, Heat, Sweets or Pressure | <input type="checkbox"/> Food Impaction |
| <input type="checkbox"/> Clenching or Grinding | <input type="checkbox"/> Burning of Tongue |
| <input type="checkbox"/> Swelling or Lumps in Mouth | <input type="checkbox"/> Frequent Blisters on Lips or Mouth (cold sores) |
| <input type="checkbox"/> Pain Around the Ear | <input type="checkbox"/> Unusual Sounds in Ear When Eating |
| <input type="checkbox"/> Unpleasant Taste | <input type="checkbox"/> Complications from Extractions |
| <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Orthodontic Treatment |
| <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> Oral Habits (i.e. fingernail biting, etc.) |
| <input type="checkbox"/> Cigarettes, Pipe or Cigar Smoking | <input type="checkbox"/> Frequency of Brushing _____ Times per day |
| <input type="checkbox"/> Dental Floss | <input type="checkbox"/> Inter Dental Stimulators |
| <input type="checkbox"/> Anti-plaque Rinses | <input type="checkbox"/> Fluoride Supplements |

ARE YOU UNDER THE CARE OF A PHYSICIAN NOW? _____

ARE YOU TAKING ANY MEDICATION NOW? _____

HAVE YOU BEEN A PATIENT IN THE HOSPITAL IN THE LAST TWO YEARS? _____

HAVE YOU HAD ANY MAJOR OPERATION? _____ IF SO, WHAT? _____

PHYSICIAN'S NAME _____ DATE OF LAST EXAM _____

ADDRESS _____ PHONE _____ FAX _____

CITY _____ STATE _____ ZIP _____



HEALTH HISTORY

Patient's Name _____ Phone No. _____

Place a mark on "YES" or "NO" to indicate if you have had any of the following:
HAVE YOUR BEEN ADVISED BY YOUR PHYSICIAN THAT YOU NEED TO BE PRE-MEDICATED FOR DENTAL TREATMENT? YES NO

Anemia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Eye Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Respiratory Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Arthritis, Rheumatism	<input type="checkbox"/> YES <input type="checkbox"/> NO	Fainting or Dizziness	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rheumatic Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO
Artificial Heart Valve	<input type="checkbox"/> YES <input type="checkbox"/> NO	Frequent Ear Infections	<input type="checkbox"/> YES <input type="checkbox"/> NO	Scarlet Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO
Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Headaches	<input type="checkbox"/> YES <input type="checkbox"/> NO	Shortness of Breath	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Murmur	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sinus Trouble	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blood Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stents	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blood Thinners	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis Type _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stroke	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blood Transfusion	<input type="checkbox"/> YES <input type="checkbox"/> NO	Herpes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Swollen Neck Glands	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO	High Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Thyroid Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chemical Dependency	<input type="checkbox"/> YES <input type="checkbox"/> NO	HIV Positive/AIDS	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tuberculosis/TB	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chemotherapy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Jaundice	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tumor or Growths	<input type="checkbox"/> YES <input type="checkbox"/> NO
Circulatory Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Jaw Pain	<input type="checkbox"/> YES <input type="checkbox"/> NO	Ulcer or Colitis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Congenital Heart Lesions	<input type="checkbox"/> YES <input type="checkbox"/> NO	Joint Replacement (Knee, Hip, etc.)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Venereal Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cortisone Treatments	<input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Women: Are you pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO Due Date _____ Are you nursing? <input type="checkbox"/> YES <input type="checkbox"/> NO Are you taking birth control pills? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Cough, Persistent or Bloody	<input type="checkbox"/> YES <input type="checkbox"/> NO	Liver Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Depression	<input type="checkbox"/> YES <input type="checkbox"/> NO	Low Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Mitral Valve Prolapse	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Emotional Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Nervousness	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Emphysema	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pacemaker	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Epilepsy/Seizures	<input type="checkbox"/> YES <input type="checkbox"/> NO	Radiation Treatment	<input type="checkbox"/> YES <input type="checkbox"/> NO		

MEDICATIONS

Have you ever taken any of the following Bisphosphonates? _____
 Fosamax _____ Boniva _____ Actonel _____ Other _____

Describe any current medical condition or treatment, even though not listed above.

ALLERGIES

- | | |
|-------------------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfur |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Local Anesthesia (Novocaine) | _____ |

To the best of my knowledge, all of the preceding answers are true & correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Date _____ Signature of patient _____

CURRENT MEDICATION	REASON	RE-CERTIFICATION: I certify that the answers given are correct to the best of my knowledge.		
		DATE	CHANGE	SIGNATURE

RICHARD H. CHANIN, D.D.S.
&
GREG B. CINKSI, D.M.D.
900 MAIN STREET
HOLBROOK, NEW YORK 11741
(631) 981-5600

Acknowledge of Receipt of Notice of Privacy Practices
And Consent for Disclosure for Treatment, Payment and Operations

ACKNOWLEDGEMENT AND CONSENT

SECTION A: PATIENT GIVING ACKNOWLEDGEMENT AND CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT:

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare 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 healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read this Notice carefully before signing this Acknowledgement and 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.

Right to Revoke:

You will have the right to revoke this Consent at any time by giving us written notice of your revocation. 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.

NAME: (Patient, Parent or Guardian)

I, _____, have had full opportunity to read and consider the contents of this Acknowledgement and Consent form and your Notice of Privacy Practices. I understand that, by signing this Acknowledgement and 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:** _____

Authorization to Release Health Care Information to Your Family and Friends:

I authorize you to use, release or disclose my healthcare information for treatment, payment or for healthcare operations to the following family members and friends. This authorization will remain in effect unless revoked by me in writing.

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____

Signature of Patient, Parent or Guardian:

_____ **Date:** _____



HOLBROOK PROFESSIONAL CENTER
900 MAIN STREET • SUITE 104
HOLBROOK, NEW YORK 11741

TELEPHONE 981-5600

SIGNATURE RELEASE STATEMENT

1. PROCESS ALL INSURANCE CLAIMS,
2. TO ENSURE PAYMENT FOR SERVICES RENDERED,
3. TO RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES, AND
4. TO RELEASE INFORMATION TO OTHER MEDICAL/DENTAL PROVIDERS, WHEN NECESSARY, FOR YOUR TREATMENT.

I authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care. I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to Dr. Chanin. 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.

Please Print

Patient _____ Responsible Party _____

Signature _____ Date _____ Witness _____