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283 Commack Road STE 120
Commack, NY 11725
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Date: _____

Welcome Form

Patient Name: _____ Date of Birth: _____ Social Security #: _____

Home Address: _____ City: _____

State: _____ Zip: _____ Email*: _____ Home # :(____) _____ Cell #: (___) _____

Work: (____) _____ ext____ Employer: _____ Occupation: _____

Pharmacy: _____ Pharm. Telephone# :(___) _____

Employer Address: _____ **Who may we thank for referring you?** _____

Responsible Party Name: _____ Relation to patient: _____

Responsible Party DOB: ___/___/____ Soc. Sec. #: _____ Employer: _____

In the event of an emergency, who may we contact?

Name: _____ Relation: _____ Cell # :(___) _____ Work # :(____) _____

Primary Insurance Co: _____
Insurance Co. Address: _____ City: _____
State: _____ Zip: _____ Group #: _____
Insured's Name: _____ Relation: _____
Insured's Date of Birth: _____ Insured's ID#: _____
Insured's Employer: _____
Employer's Address: _____
Secondary Insurance Co: (if applicable) _____
Insurance Address: _____
Group #: _____ Insured's Name: _____ Relation: _____
Insured's Date of Birth: ___/____/_____ Insured's Employer: _____

Medical History

Do you have a personal physician? YES or NO

Physician's Name: _____ City: _____ Telephone #: (___) _____

Are you currently under the care of your physician? YES or NO

If yes, explain:

_____

Are you currently taking any prescription/over the counter or supplemental drugs? YES or NO

Are you under treatment for osteoporosis or taking any osteoporosis medications? YES or NO

Please list all medications:

_____

_____

Do you smoke or use tobacco in any other form? YES or NO

Females only

If you are women are you taking birth control? YES or NO

Are you pregnant? YES___ NO___ UNSURE____ Week#: ____ Are you nursing? _____

Have you ever had any one the following diseases or medical problems?

(Please circle all that apply or write NONE)

Anemia
Artificial Bones/ Joints/ Valves
Arthritis
Asthma
Blood Transfusion
Cancer/ Chemotherapy
Diabetes
Difficulty Breathing
Drug/ Alcohol Abuse
Emphysema/ Glaucoma
Mitral valve prolapsed
Psychiatric problem
Rheumatic/ scarlet fever
Severe/ frequent headaches
Tuberculosis

Epilepsy/ Seizures/ Fainting spell
Fever Blisters/ Herpes
Heart Attack/ Stroke
Heart Murmur
Heart surgery/ Pacemaker
Hemophilia/ abnormal bleeding
Hepatitis
High/Low Blood Pressure
HIV+/ AIDS
Hospitalization for any reason
Kidney problems
Shingles
Sinus Problems
Ulcers/Colitis
VenerealDisease

Please list any serious medical conditions that you have ever had:

_____

Please list any surgeries you have ever had:

_____

Are you allergic to any of the following? (Please **circle** all that apply)

Y N -Aspirin	Y N -Erythromycin	Y N -Penicillin
Y N -Codeine	Y N -Jewelry/Metals	Y N -Tetracycline
Y N -Dental Anesthetics	Y N -Latex	Y N –Other

Please List any other drugs/materials that you are allergic to: _____

_____

Please explain to us why have you come to the dentist today? _____

_____

Are you currently in pain? _____ Do you require antibiotics before dental treatment? YES or NO

If so what for? _____

Please list your Pharmacies address and telephone number

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information to inform this office of any changes in my responsibility in inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

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PATIENT HIPAA CONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

Print Patient Name _____ Date: _____

Signature _____

Relationship to Patient _____

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Financial Responsibility & Assignment of Benefits

I understand that insurance billing is provided as a courtesy and that I am financially responsible to Commack Dental Design, PLLC for all charges arising from my treatment. It is my responsibility to notify Commack Dental Design, PLLC of any changes in my health care coverage. While Commack Dental Design, PLLC verifies my insurance eligibility, exact insurance benefits cannot be determined until the health plan receives the claim. I agree to accept financial responsibility for all medical services or supplies receive by me.
I authorize direct payment from my health insurance plan to Commack Dental Design, PLLC for all services and supplies provided to me. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original. If any law, such as workers' compensation or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer.

Cancellation Policy
We understand that circumstances may arise requiring you to cancel your scheduled appointment. Please try to give us a 24 hour cancellation notice.

Consent for Treatment and Release of Information

- *I am aware of my diagnosis and wish to receive treatment from Commack Dental Design, PLLC. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me.*

- *I give permission to Commack Dental Design, PLLC to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.*

- *I authorize Commack Dental Design, PLLC to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.*

- *I certify that I have read this agreement and my signature indicates my understanding and consent.*

_____ *Date:*_____

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Cancellation and No-Show Policy

Office Hours are by appointment and we do value your time. This is a private practice and not a dental "clinic". ***Appointment time is reserved for you alone.*** *Where appropriate, we prefer to schedule longer appointments so we can complete as much dental treatment as possible during one appointment. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing you dental care. When you make an appointment please be sure that you will be able to keep it. Morning appointments are best for more complicated or extended procedures.*

Emergency and unforeseen patient treatment problems may arise causing scheduling changes. Emergencies are expected and seem to come at the most inconvenient times. If you have a dental emergency that need immediate attention, we will always offer to see you at once. We expect that other patients may be slightly inconvenienced by this but, they will understand that this is an emergency situation. At some point, ***they may need the same courtesy too!***

We understand that scheduling conflicts may arise prohibiting you from keeping your appointment. If you cannot make your scheduled appointment please notify the office as soon as possible. We do not take cancellations after hours with messages left on the answering machine. ***There will be a charge of $50.00 for a broken appointment or cancellation with less than 24 hour notice to the office.***

All appointments must be confirmed at least 24 hours before your appointment. We confirm through phone, email and text alerts. Failure to confirm your appointment may result in you losing your appointment time.

If you have any questions about our appointment cancellation and no-show policy please feel free to ask us.

I understand the above mentioned policy.

*Print Name:*_____

*Signature:*_____

*Date:*___/___/___

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COVID Patient Screening Form

Patient Name:_____ **Birthdate**_____

Do you have a fever or have you felt hot or feverish recently (14-21 days)?	Yes No
Are you having shortness of breath or other difficulties breathing?	Yes No
Do you have a cough?	Yes No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Yes No
Have you experienced recent loss of taste or smell?	Yes No
Are you in contact with any confirmed COVID-19 positive patients? Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.	Yes No
Are you over the age of 60?	Yes No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	Yes No
Have you traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	Yes No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

Signature_____ Date:_____