YELENA VAYSMAN D.D.S.
1201 Ocean Parkway Brooklyn, NY 11230
Phone: (718) 554-7798
Fax: (718) 233-3508

New Patient Checklist

What to Expect

When you come in for your initial appointment our staff at the front desk will review the forms you have filled out and are happy to answer any additional questions you may have regarding estimating your patient paid portion (co-pay) that may be due that day, questions you may have regarding your insurance coverage amounts, covered procedures, or anything else that you may have questions about.

You are welcome to bring your children with you to your appointment. Children can come with you into the appointment rooms if necessary

While we understand that for some people there may be some anxiety about visiting the dentist, we do everything we can to make this a pleasurable experience. We want you to actually look forward to come to our office.

What to Bring

Download, complete, and print the New Patient Information Forms Pack. You can either fax these to our office in advance of your appointment or just bring them with you. Please don't forget to sign the forms.

In addition to these forms you should also bring:

- A list of any medications you are currently taking.
- Your dental insurance card.

Cancellations

If for some reason you will not be able to be at your appointment, please give us at least a 24 hour notice so that we can give that time spot to another patient who may need it. You can call us directly or send an email to _____ We look forward to serving you.

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PATIENT INFORMATION FORM

Name _____ Birth Date _____

Address _____ City _____ Zip _____

Sex: ○ Male ○ Female Marital Status: ○ Minor ○ Single ○ Married ○ Divorced

Home Phone _____ Cell _____ Work _____

E-Mail _____ Emergency # _____

Drivers license # _____

RESPONSIBLE PARTY INFORMATION

Name of person responsible for this account _____

Relationship to patient _____

Phone (if different from patient) _____

Nearest relative (not living with you) _____ Phone # _____

Nearest friend (not living with you) _____ Phone # _____

INSURANCE INFORMATION

Name of insured _____ Birth Date _____

Employer _____ Work phone _____

Insurance Company _____ Social Sec# _____

Insurance ID # _____

I understand that my full portion will be due when treatment is rendered. I understand that I will be responsible for all unpaid balances that the insurance has not paid within 90 days. I understand that failure to pay will result in the use of legal representation and that I will be responsible for all fees incurred. I also understand that if I am not able to attend a scheduled appt. I will give a 24 hr. notice. There will be a charge of $54.00 if you or a family member fails their appointment.

Signature_____ Date_____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, Under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third- party players
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a currant copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatments, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME _____

RELATIONSHIP TO PATIENT _____

SIGNATURE _____

DATE _____

OFFICE USE ONLY

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGE, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW:

DATE: _____ INITIALS: _____

REASON _____

_____

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Medical History

Patient Name: _____ Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes	○ No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	○ Yes	○ No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	○ Yes	○ No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	○ Yes	○ No	If yes, please explain: _____
Do you take, or have you taken Phen-Fen or Redux?	○ Yes	○ No	_____
Are you on a special diet?	○ Yes	○ No	_____
Do you use tobacco?	○ Yes	○ No	
Do you use controlled substances?	○ Yes	○ No	

Women: Are you
☐ Pregnant/Trying to get pregnant? ☐ Nursing?
☐ Taking oral contraceptives?

Are you allergic to any of the following?

○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic ○ Metal ○ Latex ○ Local Anesthetics
○ Other If yes, please explain: _____

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

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments _____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dentist's office of any changes in medical status.

Signature of patient, parent, or guardian: _____ Date: _____