WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date: _____

E-Mail Address: _____

Name: _____
Last First MI Mr Mrs Ms Dr

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: ____ SS#: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____)_____ Pager / Cell #: _____

Wk #: (____)_____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

2 SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: (____)_____ Ext: ____ SS #: _____

Birthdate: ___/___/___ DL #: _____

Person Responsible for Account: _____

Wk #: (____)_____ Ext: ____ Hm #: (____) _____

Billing Address: _____

Relationship: _____ SS #: _____

Employer: _____ DL #: _____

3 INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Neighbor or Relative not living with you.

His / Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____) _____

Address: _____

_____
City State Zip

4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (____)_____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

CONTINUED ON BACK

4 MEDICAL HISTORY CONTINUED

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter or herbal supplemental drugs? ☐ Yes ☐ No

Please list each one: _____

_____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you ever taken Phen-Fen? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems

Y	N	Abnormal Bleeding	Y	N	Herpes / Fever Blisters
Y	N	Alcohol / Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV+ / AIDS
Y	N	Arthritis	Y	N	Hospitalized for Any Reason
Y	N	Artificial Bones / Joints / Valves	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Liver Disease
Y	N	Blood Transfusion	Y	N	Low Blood Pressure
Y	N	Cancer /Chemotherapy	Y	N	Lupus
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Osteoporosis / Paget's Disease
Y	N	Diabetes	Y	N	Pacemaker
Y	N	Difficulty Breathing	Y	N	Psychiatric Problems
Y	N	Emphysema	Y	N	Radiation Treatment
Y	N	Epilepsy	Y	N	Rheumatic / Scarlet Fever
Y	N	Fainting Spells	Y	N	Seizures
Y	N	Frequent Headaches	Y	N	Shingles
Y	N	Glaucoma	Y	N	Sickle Cell Disease / Traits
Y	N	Hay Fever	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Stroke
Y	N	Heart Murmur	Y	N	Thyroid Problems
Y	N	Heart Surgery	Y	N	Tuberculosis (TB)
Y	N	Hemophilia	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other
Y	N	Dental Anesthetics	Y	N	Penicillin			

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

_____

5 DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you have fears about going to the dentist? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Y ☐ N Do your gums ever bleed? ☐ Y ☐ N

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

How long do you use a toothbrush before replacing it? _____

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? ☐ Yes ☐ No If yes, why? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____

Signature Date

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____

Signature Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

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CONSENT FORM FOR GENERAL DENTAL PROCEDURES

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialist, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

Further, I understand that I am entering into a contractual relationship with Gold Dental, PLLC for professional care. I further understand that meritless and frivolous claims for dental malpractice have an adverse effect upon the cost and availability of dental care, and may result in irreparable harm to a dental provider. As additional consideration for the professional care provided to me by Dr. Gold, I, agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claims(s) of medical/dental malpractice against Dr. Gold.

Furthermore, should a dental malpractice case or cause of action be initiated or pursued, I agree to use expert witness (es) who practice primarily in the same specialty as Dr. Gold. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and/or code of conduct defined for expert witnesses by the Academy of General Dentistry (AGD). Each party agrees that his/her counsel shall have the right and be free to depose the other party's expert witness (es) at least 120 days before any scheduled trial date. In further consideration for this, Dr. Gold agrees to the same stipulations.

I acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Doctor's reputation and business. Both Dr. Gold and I agree in the event of a breach to allow specific performance and/or injunctive relief.

As with all healthcare treatment, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

1. Pain, swelling and discomfort after treatment
2. Infection in need of medication, follow-up procedures or other treatment.
3. Temporary, or on rare occasion, permanent numbness, pain, tingling, or altered sensation of the lip, face, chin, gums and tongue along with possible loss of taste.
4. Damage to adjacent teeth, restorations or gums
5. Possible deterioration of your condition which may result in tooth loss
6. The need for replacement of restorations, implants or other appliances in the future
7. An altered bite in need of adjustment
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist.
9. A root tip, bone fragment or a piece of a dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop
10. Jaw fracture
11. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment.
12. Allergic reaction to anesthetic or medication
13. Need for follow-up treatment, including surgery

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

Patient	Date	Witness	Date
Print Patient Name		Parent/Legal Guardian	Date

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Gentle care combined with advanced technology
to bring you aesthetic excellence

PATIENT CONSENT/ ACKNOWLEDGMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by Gold Dental , PLLC, our staff and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this office at 845-794-5411 and requesting a revised Notice. We will also post any revised notice in the office..

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGMENT.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY.

Name_____ Date _____

60 Jefferson Street | Monticello, New York 12701 | 845.794.5411 | Fax: 845.794.5422

WELCOME TO GOLD DENTAL, PLLC

We would like to welcome you and your family to our dental practice. Please take some time to review some of our office policies.

1. 24 hours notice must be given to cancel an appointment; a no show fee of $50.00 will be charged if notice is not given.
2. Patients must make a conscientious effort toward good oral hygiene.
3. Patients must arrive to appointments ON TIME! If you arrive late for your appointment you may be asked to reschedule.
4. Please come to your appointment with good oral and personal hygiene.
5. Payments for services are due at the time that the services are rendered.
6. Patients must keep our office informed of insurance changes as well as address and phone number changes.

AN EXPLANATION OF DENTAL INSURANCE COVERAGE

In an attempt to make the handling of your claims as smooth as possible, we would like to share with you some information about what to expect in regard to your dental insurance.

NO DENTAL INSURANCE PLAN IS A "PAY-ALL"

Dental insurance should be considered as only a subsidy of dental treatment. Most insurance plans cover from 30% to 50% of the average fee for dental treatment. Some plans provide no coverage at all for certain treatments. Even plans that offer 100% coverage rarely pay for the total amount.

EVERY CASE IS DIFFERENT

The following conditions of your individual policy affect the benefits you will receive against your dental treatment:

- Allowances fixed by the insurance company for certain procedures.
- Yearly deductibles and yearly maximums.
- Dental procedures (such as cosmetic services) which the insurance company does not cover.

Your insurance company will calculate your benefits (the percentage the insurance company will pay) AFTER the above deductions have been made from the total fee.

YOUR INSURANCE BENEFITS ARE NOT DETERMINED BY THIS OFFICE

The percentage that insurance pays is determined by the type of group insurance plan your employer purchases. We can in no way alter the policy or guarantee your payments. To avoid disappointment, we strongly suggest that you contact your insurance company to learn exactly what your policy provides.

As a courtesy to you, we will gladly prepare and submit your insurance claim forms for dental treatment received in this office. However, our dental services are rendered to you, not the insurance company. Therefore, you are personally and directly responsible to us for the obligation of payment of fees. Your insurance company, of course, is responsible to you. That portion of your fee which is not covered by insurance will be estimated by our office manager and mutually satisfactory financial arrangements will be worked out before treatment is started.

Signature _____ **Date** _____

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to bring you aesthetic excellence

PLEASE MARK IF ANY OF THE BELOW APPLY TO YOU:

_____ Previous infective endocarditis

_____ Congenital Heart Disease (CHD)*

- Unrepaired cyanotic congenital heart disease, including palliative shunts and conduits
- Completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention during the first six months after the procedure**
- Repaired congenital heart disease with residual defects at the site or adjacent to the site of a prosthetic patch or prosthetic device (which inhibit endothelialization)

_____ Cardiac transplantation recipients who develop cardiac valvulopathy

* Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD

** Prophylaxis is recommended because endothelialization of prosthetic material occurs within 6 months after the procedure.

60 Jefferson Street | Monticello, New York 12701 | 845.794.5411 | Fax: 845.794.5422

To accept insurance payments, we now require that a credit/debit card be left on file with our office.

I authorize Gold Dental, PLLC to keep my signature on file and to charge my credit card account for balance of charges not paid by insurance within 60 days and not to exceed $50.00. We will call on all balances over $50.00 for authorization before charging your credit card. Any overpayment on the account will be refunded to the same credit card I use for payment.

I assign my insurance benefits to the provider listed above. I understand this form is valid unless I cancel the authorization through written notice to Gold Dental, PLLC and provide alternative payment for committed amount. I understand that this credit card information will not be shared with any outside sources.

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____ Home phone: _____

City, State, Zip: _____ Cell phone: _____

Account number: _____ Expiration Date: _____
Visa / Mastercard / Amex / Discover / Care Credit CCV _____

Cardholder Signature: _____

*If you do not leave a credit card on file an 18% billing fee will be added.