Empire Dental NY PC

Dr. Anatoly Bartov
980 E 12th Street
Brooklyn, NY 11230
(718) 377-3222

Patient Registration Form

***Personal Information*:**

Name:_____. I prefer to be called _____ [ ] Male [ ] Female
[ ] Single [ ] Married [ ] Child | Date of Birth: __/__/____ Age: ___. SSN#: _____
Home Address: _____ City:_____ State:___ Zip: _____
Home Phone#: (___)_____ Work#: (___)_____ Ext: ____ Cell#:(___)_____
E-Mail Address: _____ Employer: _____
Occupation:_____ How long working there?_____

***Dental Insurance Information*:**

Primary Insurance

Insurance Co. Name: _____ Group# _____ Member ID#: _____
Subscriber's Name: _____ Subscribers Birth Date: __/__/____
Relation to Subscriber: _____ Subscribers SSN#:_____

Secondary Insurance

Insurance Co. Name: _____ Group# _____ Member ID#: _____
Subscriber's Name: _____ Subscribers Birth Date: __/__/____
Relation to Subscriber: _____ Subscribers SSN#:_____

Patient Dental History

Reason for this visit: _____
When was your last dental visit? _____ What was done then?_____
How often did you visit the dentist before then? _____
Previous Dentist _____
Have you had a complete series of X-rays taken? If yes, when? _____
How often do you brush your teeth? _____
How often do you floss your teeth? _____

Dental History (Continued)

	Yes	No
Do your gums bleed while brushing or flossing.....	☐	☐
Are your teeth sensitive to hot or cold liquids/foods.....	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods.....	☐	☐
Do you feel pain in any of your teeth.....	☐	☐
Do you have any sores/lumps in or near your mouth.....	☐	☐
Do you have frequent headaches.....	☐	☐
Do you clench or grind your teeth.....	☐	☐
Have you noticed any loosening of your teeth.....	☐	☐
Does food tend to get stuck between your teeth.....	☐	☐
Have you ever had periodontal (gum) treatment.....	☐	☐
Do you wear any dentures/partials.....	☐	☐
Do you use tobacco.....	☐	☐

If you could change anything about your smile, what would it be?

Medical History Information

Do you have or have ever had any of the following? Check all those which apply.

Name of Physician:_____

[ ] Allergies/Hay Fever	[ ] Diabetes	[ ] Heart Surgery	[ ] Rheumatic Fever
[ ] Anemia	[ ] Epilepsy/Seizures	[ ] Hepatitis	[ ] Rheumatism
[ ] Angina	[ ] Excessive Thirst	[ ] High Blood Pressure	[ ] Sickle Cell Disease
[ ] Arthritis	[ ] Fainting/ Dizziness	[ ] HIV/AIDS	[ ] Sinus Problems
[ ] Artificial Joints	[ ] Fever Blisters/ Cold Sores	[ ] Kidney Problems	[ ] Stroke
[ ] Artificial Heart Valves	[ ] Frequent Cough	[ ] Liver Problems	[ ] Surgical Shunt
[ ] Asthma	[ ] Glaucoma	[ ] Mental Disorders	[ ] Thyroid Problems
[ ] Breathing Problems	[ ] Heart Disorder	[ ] Mitral Valve Prolapse	[ ] Tuberculosis
[ ] Cancer	[ ] Heart Infection	[ ] Osteoporosis	[ ] Ulcers
[ ] Chemical Dependency	[ ] Heart Murmur	[ ] Radiation Treatment	[ ] Venereal Disease
[ ] Chemotherapy	[ ] Heart Pace Maker	[ ] Respiratory Treatment	[ ] Yellow Jaundice

Do you have any health problems which were not listed or need further explanation?

_____

Have you been admitted to the hospital in the past two years? [ ] Yes [ ] No

Are you taking any medications? If yes, please list: _____

Are you allergic to any medications, if yes please select which one(s):

[ ] Aspirin [ ] Penicillin [ ] Codeine [ ]Iodine [ ] Metal [ ] Latex [ ] Other:_____

Women (Please Check): [ ] Pregnant [ ] Trying to get pregnant [ ] Nursing [ ] Oral Contraceptives

Dr. Anatoly Bartov, D.M.D.

We are honored you have chosen us for you dental care. In order to keep a completely professional and up front business relationship with our patients, we ask that you read and state that you understand our payment policy and our insurance policy. If you do not have dental insurance please skip down to the bottom of the page.

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

- I understand that my insurance policy is a contract between my insurance company and myself. The contract is not between Dr. Anatoly Bartov and my insurance company. I know that I am fully responsible for all charges resulting from services rendered to me, including the balance remaining after payment of possible insurance benefits.

- As a courtesy we will file all claims over $150.00 at no charge.

- In instances where pre-determinations are approved, you may pay your co-payment and we will file for the remaining balance. However, if payment from you insurance company is not received within 30 days we will notify you of the balance due and your payment is expected in full at that time.

- I understand that should my account become delinquent, I will be legally responsible for all cost involved with the collection of this account including all court cost, reasonable attorney fees and all other related cost as allowed under New York State law.

Print Name Signature Date

Disclaimer:

- All co-pays and payments are due at time of services. If any payment arrangements need to be made, please speak with the office manager prior to your appointment date.
- **Please understand that there will be a $75 fee for any appointments cancelled without a twenty four hour notice**
- Please sign and date that you understand and agree to our office policy. If there are any questions please ask us before signing.

THANK YOU!

Print Name Signature Date

HIPAA: Patient Consent Form

The department of Health & Human Services has established a "privacy rule" to help insure that personal health information is protected for privacy. The privacy rule was also created in order to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationship with you (such as laboratories that only interact with doctors not patients) and may have to disclose personal health information for purposed of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal 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 Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Signature: _____

Print Name: _____

Date: _____