Date: ______________

DENTAL LOVE LLC

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dentallovellc@gmail.com
Tel: 212-752-8722
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Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name: ____ Soc. Sec. #: ____________________
Last Name First Name Initial

Address: ______________________________Apt.#: ______________________________

City: ______________________________State: ______________ Zip: ______________

Sex: F ☐ M ☐ Age: _____ Birthdate: ______________ Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Phone Number: ______________________________

Email Address: ____

Patient Employed by__________________________ Occupation__________________________

Whom may we thank for referring you?____

In case of emergency who should be notified? ____

Primary Insurance

Person Responsible for Account:

____
Last Name First Name Initial

Relation To Patient: ______________________ Birthdate: __________ Soc. Sec. #: ______________

Address (If different from patient's)____

City: ____________________ State: ________ Zip: _______ Phone: ____________________

Person Responsible Employed By: ______________________ Occupation: ____________________

Insurance Company: ____

Subscriber/Member ID#: __________________ Group #: ____________ Contract #: ____________

Additional Insurance

Is Patient covered by additional Insurance? ☐ Yes ☐ No

Subscriber Name: ________________________ Relation to Patient:__________ Birthdate: ________

Address (If different from patient's)__________________________________City: ______________
State: ________ Zip: _______ Phone: ____________________

Insurance Company: ____

Subscriber/Member ID#: __________________ Group #: ____________ Contract #: ____________

Subscriber Employed by: ______________________

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Dental History

Reason for Today's Visit: ______________________________ Date of Last Dental Care: ______________________

Former Dentist: ______________________________ Date of Last Dental X-Rays: ______________________

Address: ____

Check (✓) if you have had problems with any of the following:

☐ Bad Breath	☐ Grinding Teeth	☐ Sensitivity to Hot
☐ Bleeding Gums	☐ Loose Teeth or Broken Fillings	☐ Sensitivity to Sweets
☐ Clicking or Popping Jaw	☐ Periodontal Treatment	☐ Sensitivity when Biting
☐ Food Collection Between Teeth	☐ Sensitivity to Cold	☐ Sores or Growths in your Mouth

How often do you floss? ______________________ How often do you Brush? ______________________

Medical History

Physician's Name: ______________________________ Date of Last Visit: ______________________

Have you had any serious illnesses or operations? __________ If yes, describe: ______________________

Have you ever had any complications following dental treatment? __________ If yes, describe: ______________________

Do you have any health problems that need further clarification? __________ If yes, describe: ______________________

(Women) Are you currently pregnant? __________ Nursing? __________ Taking Birth Control Pills? __________

Check (✓) if you have or have had any of the following:

☐ Anemia	☐ Cortisone Treatments	☐ Hepatitis	☐ Stomach Problems
☐ Arthritis, Rheumatism	☐ Cough, Persistent	☐ High Blood Pressure	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Cough Up Blood	☐ HIV/AIDS	☐ Skin Problems/Disease
☐ Artificial Joints	☐ Diabetes	☐ Jaw Pain	☐ Stroke
☐ Asthma	☐ Depression	☐ Kidney Disease	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Epilepsy	☐ Liver Disease	☐ Thyroid Problems
☐ Blood Disease	☐ Fainting	☐ Mitral Valve Prolapse	☐ Tabacco habit
☐ Cancer	☐ Glaucoma	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Headaches	☐ Radiation Treatment	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Murmur	☐ Respiratory Disease	☐ Ulcer
☐ Circulatory Problems	☐ Heart Problems	☐ Rheumatic Fever	☐ Venereal Diseade

MEDICATIONS

List medications you are currently taking:

____

____

ALLERGIES

____

____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change to my health, I will inform my doctors at the next appointment without fail.

X______________________________ Date ______________________

Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charge whether or not paid by insurance.

X______________________________ Date ______________________

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DENTAL LOVE LLC FINANCIAL AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

General: Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

MISSED APPOINTMENTS: Unless we receive notice of cancellation at least 24 hours in advance, you will be charged $50.00 Please help us service you better by keeping scheduled appointments.

INSURANCE: Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf. Please be aware that some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT: FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

Please indicate below the form of payment you wish to choose.

( ) Cash or check

( ) Visa, MasterCard, Discover

( ) If you qualify, a monthly payment plan is available for your convenience.

If payment is delinquent, the patient will be responsible for payment of collection.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Signature: ____

Date: ___________________________________