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PATIENT'S HISTORY INFORMATION

PLEASE PRINT

Date: _____

PATIENT'S NAME: (FIRST) _____ (LAST) _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP _____

SOCIAL SECURITY NUMBER: _____ LICENSE NUMBER: _____

TELEPHONE NUMBER (HOME): _____ (BUSINESS): _____

DATE OF BIRTH: _____ AGE: _____ CELL#: _____

MARITAL STATUS: () SINGLE () MARRIED () WIDOWED () DIVORCED

EMAIL ADDRESS: _____

FATHER'S NAME: _____ MOTHER'S NAME: _____

SPOUSE'S FIRST NAME: _____

PATIENT'S OCCUPATION: _____

EMPLOYER: _____

PRIMARY INSURANCE COMPANY: _____

ID # _____ GROUP #: _____

SECONDARY INSURANCE COMPANY: _____

ID # _____ GROUP #: _____

REFERRED BY: (NAME OF RELATIVE, DOCTOR, FRIEND, ADVERTISEMENT, ETC.)

HAVE WE SEEN ANY OTHER MEMBERS OF YOUR FAMILY? NAME & RELATIONSHIP

RELATIVE WE MAY CONTACT INCASE OF EMERGENCY (LIVING WITH YOU)

RELATIVE WE MAY CONTACT INCASE OF EMERGENCY (NOT LIVING WITH YOU)

NAME: _____ ADDRESS: _____

RELATIONSHIP: _____ TELEPHONE#(HOME): _____ (WORK): _____

METHOD OF PAYMENT: () CASH () CHECK () CHARGE

PAYMENT IS EXPECTED AT THE TIME OF VISIT UNLESS ARRANGED OTHERWISE IN ADVANCE

DENTAL HEALTH HISTORY

(Confidential)

Patient Name: _____ Birthdate _____

Reason for Today's Visit _____

Former Dentist _____

Address _____

Date of Last Dental Care _____ Date of Last Dental X-Rays _____

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to Hot |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose teeth or Broken Fillings | <input type="checkbox"/> Sensitivity to Sweets |
| <input type="checkbox"/> Clicking/Popping Jaw | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Sensitivity when Biting |
| <input type="checkbox"/> Food Collection between teeth | <input type="checkbox"/> Sensitivity to Cold | <input type="checkbox"/> Sores/Growths in 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 illness or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? ___Yes ___ No If yes, give approximate dates _____

Women - Are you pregnant? ___Yes ___ No Nursing? ___Yes ___ No Birth Control Pills ___Yes ___ No

Check if you have or have had any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nerve Problems | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems, Describe _____ | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hemophillia | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever | |
| | <input type="checkbox"/> High Blood Pressure | | |
| | <input type="checkbox"/> HIV Positive | | |

MEDICATIONS

Please list medications you are currently taking: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

ALLERGIES

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Penicillin | |

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any error or omissions that I may have made in the completion of this form.

Patient Signature

Date

FINANCIAL AGREEMENT

Dear Patient:

As a courtesy to you, we have agreed to submit the charges for your recent office visit, and/or other services and await payment directly from your insurance carrier. However, all patients are responsible for their deductibles, co-payments and co-insurance. Please advise which method of payment you will be using below:

_____	Payment by Cash	_____	Payment by Check
_____	Payment by Credit Card	_____	Payment by Care Credit [®]
_____	Chase Health Advance		

We offer Care Credit[®] and Chase Health Advance because your smile is important to us. It is a convenient, low minimum monthly payment program for your entire family specifically designed to pay for treatment not covered by insurance.

In order for us to submit to your insurance company, we must have a copy of your current insurance card. It is your responsibility to notify us of any change in your insurance information: Should any information change and we are unaware you will be billed directly and responsible to submit the charges to your insurance carrier.

We will bill dental insurance for those patients that have dental coverage, but you are expected to pay the deductible and co-payment on the day of the services. The co-payment is an ESTIMATE provided by this office, it is to be considered as a guideline until the final insurance payment has been received. We can make NO guarantees of the insurance payments, including available remaining benefits. We are not in network with any dental plans, but we do take most insurance towards payment, providing you have a PPO plan.

When we bill a patient's insurance company, the policy of our office is to await payment for ninety (90) days from the date of service. After the ninety (90) day period, if no payment is received from your insurance carrier, we will bill you for the services rendered. If payment is received from your insurance carrier after your remittance is received we will forward a refund to you.

If you should receive the insurance check instead of our office, please send us the original check from your insurance company and any applicable deductible, co-payments and co-insurance, along with a copy of the explanation of benefits. (We MUST have a copy of this explanation of benefits to properly credit your account.)

FINANCIAL AGREEMENT (CONT.)

Our office is a fully approved and accredited user of the VISA/MASTERCARD/DISCOVER Health Care Incentive Program, which will enable you to use your credit card to automatically cover amounts not paid by your insurance company.

Please initial below:

_____ Guarantee your insurance co-payments with your credit card.

Patient Name _____

() VISA () MASTERCARD () DISCOVER

ACCOUNT NUMBER: _____ - _____ - _____ - _____

EXPIRATION DATE: ____ / ____ Security Code: ____

I authorize: Drs Russ & Sender to charge my payment card for the balance of fees not paid by my insurance company after ninety (90) days.

Signature of Cardholder / Patient

I authorize the release of any dental records or other information necessary to process my claims. I also authorize payment be made directly to my provider.

_____ Please Initial

In the event your account has to be sent to our attorney for collection, you will be responsible additionally for:

- A. Attorney Fees which are 1/3 of balance due.
- B. Costs expended by the attorney.
- C. Interest.

I HAVE READ AND UNDERSTAND THE ABOVE:

PATIENT'S NAME (PRINT): _____

PATIENT'S SIGNATURE: _____ DATE: _____

Smile Quiz

Name: _____

1. Color of Teeth

- 1 Not Satisfied
- 2
- 3 Somewhat Satisfied
- 4
- 5 Very Satisfied

2. Crooked or Overlapping Teeth

- 1 Not Satisfied
- 2
- 3 Somewhat Satisfied
- 4
- 5 Very Satisfied

3. Presence of Cracks/Chips/Missing Teeth

- 1 Not Satisfied
- 2
- 3 Somewhat Satisfied
- 4
- 5 Very Satisfied

4. Size / Length of Teeth

- 1 Not Satisfied
- 2
- 3 Somewhat Satisfied
- 4
- 5 Very Satisfied

5. Presence of a Gummy Smile

- 1 Not Satisfied
- 2
- 3 Somewhat Satisfied
- 4
- 5 Very Satisfied

Total : _____

Divide by: _____ 5 _____

= _____

Your Smile Rating is: _____

If your average rating was between 1 and 3, talk to your dental professional today about cosmetic treatments to obtain the smile you've always dreamed of. Present this sheet to your dentist to discuss your treatment options. Take your smile from ordinary to extraordinary.

