Brooklyn Dental Group
1 . Flatbush Ave., Brooklyn, N.Y. 11210

PATIENT INFORMATION AND HEALTH HISTORY

PLEASE ANSWER ALL QUESTIONS, SO WE CAN PROTECT YOUR HEALTH AND SERVE YOU BETTER. YOUR ANSWERS ARE CONFIDENTIAL.

Today's Date _____

Last Name _____ First Name _____ Middle Initial _____ Social Security # _____

Marital Status _____ Sex _____ Date of Birth _____ Referred by _____

Home Address _____

Employed By _____ Home Phone _____

Business Address _____ Business Phone _____

Are you covered by your employer's dental insurance? Yes / No
Are you covered by your spouse's dental insurance? Yes / No
Who is responsible for the payment of services rendered? _____

DENTAL HISTORY

Date of last dental exam _____ Reason for today's visit _____

YES	NO		YES	NO	
☐	☐	Teeth sensitive to cold, heat, sweets or pressure	☐	☐	Complications from extractions
☐	☐	Bleeding gums. How long? _____	☐	☐	Periodontal (gum) treatment
☐	☐	Clenching or grinding	☐	☐	Orthodontic treatment (braces)
☐	☐	Pain around ear/headaches	☐	☐	Cigarettes, pipe or cigar smoking, etc.
☐	☐	Bad breath/Unpleasant taste	☐	☐	Frequency of brushing _____
☐	☐	Unfavorable dental experience	☐	☐	Other _____

MEDICAL HISTORY

Physician's name _____ Office phone _____ Date of last physical exam _____

YES	NO		YES	NO		YES	NO	
☐	☐	Any heart ailments	☐	☐	Asthma, hay fever, allergies	☐	☐	Eye disorders
☐	☐	Heart murmur	☐	☐	Sinus problems	☐	☐	Neurological problems
☐	☐	Rheumatic fever	☐	☐	Tuberculosis	☐	☐	Epilepsy, seizures
☐	☐	Any prosthetic valves or joints	☐	☐	Diabetes	☐	☐	Cancer
☐	☐	High / low blood pressure	☐	☐	Kidney problems	☐	☐	Radiation treatments
☐	☐	Anemia or blood disorder	☐	☐	Liver problems or hepatitis	☐	☐	AIDS, HIV positive
☐	☐	Excessive bleeding from cut/extraction	☐	☐	Thyroid	☐	☐	Venereal disease
☐	☐	Arthritis	☐	☐	Ulcer or colitis	☐	☐	Other _____

Are you allergic to ☐ penicillin; ☐ novocain; ☐ other? _____
Are you currently taking any medication? Please list _____
Have you ever had any surgery? What/When? _____
If you are a woman, are you pregnant? If so, what month? _____

I have reviewed the above information and it is correct to the best of my knowledge. I understand that I am responsible for payment. I am also responsible for any legal fees and court costs necessary to secure delinquent balance.

SIGNATURE _____ DATE _____
(Parent or guardian, if patient is a minor)

COMMENTS: _____

_____ SIGNATURE OF DENTIST _____ DATE _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Brooklyn Dental Group

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

American Dental Association Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Insurance Company Name
Address 1
Address 2
City ST ZIP

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code
Other Insurance Company Name
Address
City ST ZIP

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Policyholder Name
Address 1
Address 2
City ST ZIP

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Patient Name
Address 1
Address 2
City ST ZIP

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Primary									
A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee 0

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____ Date
Patient/Guardian signature

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____ Date
Subscriber signature

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
Martin Bodek
1491 flatbush ave
Brooklyn,NY 11210

49. NPI: 1831250588 | 50. License Number: 040812 | 51. SSN or TIN: 112916910

52. Phone Number: (718) 859 - 3440 | 52A. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X_____ Date
Signed (Treating Dentist)

54. NPI | 55. License Number

56. Address, City, State, Zip Code: 1491 flATBUSH AVE BROOKLYN NY 11210

56A. Provider Specialty Code

57. Phone Number (718) 859 - 3440 | 58. Additional Provider ID