White Plains Dental, P.L.L.C.
19 S Broadway, White Plains, NY 10601
Tel: 914 948-0088

PATIENT REGISTRATION

Date:_____________________

First Name: __________________ Last Name: ___________________ Middle Initial: ___
E-Mail Address: _________________________ Preferred Name: _____________ Birth date: ______________ SS#: ___________________
Address: ____________________ Apt #: ______ City:________
State: ____________ Zip_____ Home Phone _________________ Work _____________
Cell phone: __________________ Referred By: _________________

Responsible Party:

(If the patient is younger than 18 years old)
First Name: ___________________ Last Name: ___________________ Middle Initial: ___
E-Mail Address: ___________________ Preferred Name: ___________________ Birth date: ___________________ SS#: ___________________
Address: _______________________ Apt #: _______ City: __________________
State: ____________ Zip________ Cell phone _________________
Are you: Married______ Single_____ Divorced _________ Widowed_____

Dental Insurance Information:

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive your maximum allowable benefits. but we can NOT guarantee payment from them. In order to do this, we need your insurance card and/or insurance policy with you on your first visit of every calendar year. (Your insurance year may not be January-December) If your insurance has not paid within 60 days of services rendered, you will need to make full payment to his office. You will be reimbursed when your insurance company pays. After 60 days the patient is responsible to pursue payment from the insurance company. All current documentation will be provided by mail in order to assist your inquiries. The insured, and/or the employer through whom the policy was purchased, has a better ability to deal with the insurance company, as they are the client of the insurance company.

Policy Holder: ________________________ Insurance Company: ______________________
Policy Holder DOB: _____________________ Group #: ______________________ Policy Holder SS#: ______________________ Claims Address:_______________________

Signature of patient or parent if minor: ____

Date: _____________

Preferred Pharmacy Information:

Pharmacy Name: ____________________________ Pharmacy Address: _________________________________

Pharmacy Phone Number: ___________________________________

Prescription Insurance Information:

Rx Insurance Provider: _____________________________ Rx Member ID Number: _______________________

Rx Group Number (if applicable): _____________________ BIN Number (if applicable): _________________

PCN Number (if applicable): ________________________________

Additional Notes: If you have any specific preferences or instructions regarding your prescriptions, please include them here:

Signature: __________________________________ Date: ___________________________

MEDICAL HISTORY

Physician's Name_______________ Address__________________________ Phone _____________

Please list all medications you are currently taking or using prescription and OTC.

Are you currently under a Physicians care? Y/N Please list any serious medical condition(s) that you have experienced. ____________________

Do you need pre-medication for any procedures? Y/N Do you or have you experienced any of the following? (Please circle **Y/N)**

Abnormal Bleeding **Y/N**
Colitis **Y/N**
Heart Murmur **Y/N**
Liver Disease **Y/N**
Alcohol Use **Y/N**
Congenital Heart Defect **Y/N**
Heart Surgery **Y/N**

Lupus **Y/N**
Anemia **Y/N**
Diabetes **Y/N**
Hemophilia **Y/N**
Pacemaker **Y/N**
Artificial Joints **Y/N**
Emphysema **Y/N**
Hepatitis **Y/N**
Radiation Treatment **Y/N**

Artificial Valves **Y/N**
Fever Blisters **Y/N**
Herpes **Y/N**
Seizures **Y/N**
Asthma **Y/N**
Glaucoma **Y/N**
High Blood Pressure **Y/N** Tobacco
Smoke/chew **Y/N**

Cancer **Y/N**
Headaches **Y/N**
HIV+/AIDS **Y/N**
Tuberculosis (TB) **Y/N** Chemotherapy **Y/N** Heart Attack **Y/N**
Kidney Problems **Y/N**
Venereal Disease **Y/N**

Women: Are you taking birth control pills? **Y/N** Are you pregnant? **Y/N** Week #: _____ Are you nursing? **Y/N**

Are you allergic to any of the following?
Latex **Y/N** - Ibuprofen **Y/N** – Codeine **Y/N**- Barbiturates **Y/N** - Jewelry/Metals **Y/N** - Sulfa Drugs **Y/N**
Aspirin **Y/N** -Tetracycline **Y/N** - Dental Anesthetics **Y/N** - Penicillin **Y/N**
Are you allergic to anything not listed if so what? ________________________________

What Pre- Medication is needed prior to your dental appointment if any?
____

Have you ever tested positive for COVID 19? Y/N If so when? ____________ Since then, have you tested negative? Y/N If so when? __________

I affirm that the information I have given is correct to the best of my knowledge. All information herein will be held in the strictest confidence and it is my responsibility to inform onsite dental staff of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need, including x rays, photographs, study models, or any aids deemed appropriate to make a thorough diagnosis of my dental needs.

***SIGN*________________________________*DATE*____________**

White Plains Dental
19 S Broadway Whiteplains, NY 10606 Tel:914-948-0088

Dental Office 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(s) 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 services not directly provided by the dentist.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation 24-48 hours in advance, you will be charged $75. 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 your 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 some or perhaps all of the service 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.

PAYMENTS:

FULL PAYMENTS are due at the time of service. If insurance benefits apply, ESTIMATED PATIENT COPAYMENTS 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, American Express
( ) If you qualify, a monthly payment plan is available at your convenience,

By signing, I have read, understood and agreed to the terms and conditions of this financial Agreement.

Signature: _______________

Date: ___________________