Welcome

Date_____

Patient's Name_____

Date of Birth_____ Gender_____

If Child: Parent's Name_____

How do you wish to be addressed_____
Single Married Separated Divorced Widowed Minor

Residence- Street_____

City_____ State_____ Zip_____

Business Address_____

Telephone: Res._____ Bus._____

Fax_____ Cell Phone_____

eMail_____

Patient/Parent Employed By_____

Present Position_____ How Long Held_____

Spouse/Parent Name_____

Spouse Employed By_____

Present Position_____ How Long Held_____

Who is Responsible for the account_____

Drivers License No._____

Method of Payment: Insurance Cash Credit Card

Purpose of Call_____

Other Family Member in this practice_____

Whom may we thank for this referral_____

Patient/parent Social Security No._____

Spouse/parent S.S. No._____

Someone to notify in case of emergency not living with you_____
_____

Dental Insurance
1st COVERAGE

Employee_____ Date of Birth_____
Relationship to patient_____
Employer Name _____
Name of Insurance Co._____
Address_____
_____
Telephone_____
Program or Policy # _____
Social Security No._____
Union Local or Group_____

Dental Insurance
2nd COVERAGE

Employee_____ Date of Birth_____
Relationship to patient_____
Employer Name _____
Name of Insurance Co._____
Address_____
_____
Telephone_____
Program or Policy # _____
Social Security No._____
Union Local or Group_____

Consent:
I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.
I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.
I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature
_____Date_____

Dental History

Patient's Name_____Date of Birth_____

1. Purpose of Initial Visit_____
2. Are you aware of a problem_____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Previous dentist's Name _____Tel_____
   Address_____
6. When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW' ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits?.....YES NO
8. Were dental x-rays taken?.....YES NO
9. Have you lost any teeth or have any teeth been removed……..YES NO
   Why? _____
10. Have they been replaced……YES NO
11. How have they been replaced?
    a. Fixed bridge_____AGE_____
    b. Removable bridge_____AGE_____
    c. Denture_____AGE_____
    d. Implant_____AGE_____
12. Are you unhappy with the replacement?.....YES NO
    If yes, explain_____
13. Would you like to know about permanent replacements?.....YES NO
14. Have you ever had any problems or complications with previous dental treatments?.....YES NO
    If yes, explain_____
15. Do you clench or grind your teeth?.....YES NO
16. Does your jaw click or pop?.....YES NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear?.....YES NO
18. Do you have frequent headaches, neckaches or shoulder aches?.....YES NO
19. Does food get caught in your teeth?.....YES NO
20. Are any of your teeth sensitive to: □ Hot? □ Cold? □ Sweets? □ Pressure?
21. Do your gums bleed or hurt?.....YES NO
    When? _____
22. Do you experience dry mouth?.....YES NO
23. Do you drink any carbonated beverages? Soda, seltzer water, etc……YES NO
24. Do you use lemons in your beverages?.....YES NO
25. How often do you brush your teeth? _____When? _____
26. Do you use floss?.....YES NO
    How often? _____
27. Are any of your teeth loose, tipped, shifted or chipped?.....YES NO
28. Are you unhappy with the appearance of your teeth?.....YES NO
29. How do you feel about your teeth in general? _____
30. Do you feel your breath if offensive at times?.....YES NO
31. Have you ever had gum treatment or surgery?.....YES NO
    What? _____
    Where?_____
    When?_____
32. Have you had any orthodontic work?.....YES NO
33. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike_____
34. Do you have any questions or concerns?.....YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/ GUARDIAN'S SIGNATURE_____DATE_____

DENTIST"S SIGNATURE_____DATE_____

COMMENTS

Med. Alerts

Medical History

Patient's Name_____Date of Birth_____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW' ON THE LINE AFTER THE QUESTION.

COMMENTS

1. Physician's Name_____Tel:_____
   Address_____
   _____
2. Are you under a physician's care?.....YES NO
   Since when_____Why_____
3. When was your last complete physical exam?.....YES NO
4. Are you taking any medications or substances?.....YES NO
   (If yes, please list medications in comments section or on the back of this form.)
5. Do you routinely take health related substances? (Vitamins, herbal supplements, natural products)....YES NO
6. Are you allergic to any medications or substances? (please list).....YES NO
7. Do you have any other allergies or hives?.....YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications?.....YES NO
9. Are you sensitive to any metals or latex?.....YES NO
10. Are you pregnant or suspect you may be?.....YES NO
11. Do you use any birth control medications?.....YES NO
12. Have you ever been treated for or been told you might have heart disease?.....YES NO
13. Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse?.....YES NO
14. Have you ever had rheumatic fever?.....YES NO
15. Are you aware of any heart murmurs?.....YES NO
16. Do you have high or low blood pressure? (please circle).....YES NO
17. have you ever had a serious illness or major surgery.....YES NO
    If so, explain_____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition.....YES NO
19. Have you ever taken Fosamax, Zometa, Aredia, or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis?.....YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism?.....YES NO
21. Do you have any artificial joints/ prosthesis?.....YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc?.....YES NO
23. Have you ever bled excessively after being cut or injured?.....YES NO
24. Do you have any stomach problems?.....YES NO
25. Do you have any kidney problems?.....YES NO
26. Do you have any liver problems?.....YES NO
27. Are you diabetic.....YES NO
28. Do you have fainting or dizzy spells?.....YES NO
29. Do you have asthma?.....YES NO
30. Do you have epilepsy or seizure disorders?.....YES NO
31. Do you or have you had venereal or any sexually transmitted disease?.....YES NO
32. Have you tested HIV positive?.....YES NO
33. Do you have AIDS?.....YES NO
34. Have you had or do you test positive for hepatitis?.....YES NO
35. Do you or have you had H.B.?.....YES NO
36. Do you smoke, chew, use snuff or any other forms of tobacco?.....YES NO
37. Do you regularly consume more than one or two alcoholic beverages a day?.....YES NO
38. Do you habitually use controlled substances?.....YES NO
39. Have you had psychiatric treatment?.....YES NO
40. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), Dexfenfluramine (redux), or other weight loss products?.....YES NO
41. Do you have any disease condition, or problem not listed? If so, explain_____
42. Is there anything else we should know aboutyour health that we have not covered in this form?_____
43. Would you like to speak with Doctor privately about any problem?

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/ GUARDIAN'S SIGNATURE_____DATE_____

DENTIST"S SIGNATURE_____DATE_____

Med. Alerts

HIPPA NOTICE OF PRIVACY PRACTICES

Anthony E. Chillura, DMD; PC
Supriya Verma, DMD
67 Wall Street Suite 2508
New York, NY 10005
212 344 9317

This notice describes how medical information about you may be disclosed and how you can get access to this information. Please review it carefully.

This notice goes into effect on April 14, 2003 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that medical information is personal and we are committed to protecting it. We create a record of the care and services your receive at our practice. We need the record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use or disclosure of medical information.

2. OUR LEGAL DUTY

Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices and your rights regarding your medical information.
3. Follow the terms of the notice that is now effect.

We have the right to:

1. Change the privacy practices and the terms of this notice at anytime, provided that law permits the changes.
2. Make the changes in our policy practices and the new terms of our notice effective for medical information that we keep, including information previously created or received before the changes.

3. USES AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use of disclosure will be listed. However, we have listed all the ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide, may be revoked, at anytime, by writing to us.

For Treatment:

The HIPPA regulations permit nearly unlimited sharing information among providers who are involved in a patient's treatment. Uses and disclosures of information commonly included:

A. Collection of information from the patient by a physician or other medical practitioner, per forming diagnostic tests and reviewing results.
B. Consulting with other providers on diagnosis or treatment.
C. Referring a patient to another provider
D. Transmitting information to another provider, such as phoning prescriptions into a pharmacy or placing an order for an ice machine, brace or other durable medical equipment.

For Payment:
We are permitted to disclose to the patient's health plan any information needed to process a claim. For example; to determine whether a patient is eligible for coverage under a health plan, to determine whether tests or services are covered under a health plan, to submit a claim or inquire

about the status of a claim, to process payment or claims remittances, to process credit card transactions.

FOR HEALTH CARE OPERATION:

Staff may use and disclose only the "minimum necessary" information for the task at hand. This includes: maintenance of medical records, maintenance of medical records, maintenance of accounting records, quality assurance activities, staff performance evaluations, conducting financial and management audits, investigating complaints, supporting legal activities, resolving grievances and general business management.

LAW ENFORCEMENT:

Your health information may be disclosed to law enforcement, agencies to facilitate investigations, inspections or mandated reporting. Your health information may be disclosed to public health agencies required by law.

HIPPA NOTICE OF PRIVACY PRACTICES

Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.

INDIVIDUAL RIGHTS:

You have the right to request restorations on the use and disclosure of your protected health information, the right to receive confidential communications regarding your treatment and condition, the right to inspect and copy your health information, the right to amend or submit corrections to your health information, the right to receive a printed copy of this notice.

As permitted by federal regulation, we require that requests to copy protected information be submitted in writing. If you would like to submit a comment about our privacy practices you may do so by sending a letter outlining your concerns. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing that cause of your concern to:

Anthony E. Chillura, DMD; PC
67 Wall Street, Suite 2508
New York, NY 10005
212 344 9317

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided the opportunity to review the contents.

Name: _____

Signature: _____

Date: _____

Office Use Only: _____

Anthony E. Chillura, DMD; PC
67 Wall Street, Suite 2508
New York, NY 10005
(212)344-9317
wallstdental.com

PATIENT ATTENDANCE PLOICY AGREEMENT

Over the past 20 years, our office strived to provide each patient with the highest quality of care while attempting to accommodate your schedule and ours. To that end, we provide reserved slots for each patient in order to minimize waiting times and assure quality and continuity of treatment.

Cancellations, especially last minutes ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of other patients. We ask for your full cooperation with our policy as follows:

- **IF YOU ARE UNABLE TO KEEP A SCHEDULED APPOINTMENT, PLEASE NOTIFY US 2 BUSINESS DAYS IN ADVANCE.**

- **ALL CANCELLATIONS AND NO-SHOWS WILL BE DOCUMENTED IN OUR RECORDS, AND A CHARGE WILL BE APPLIED FOR THE APPOINTMENT.**

- **IF YOU ACCUMULATE 3 CANCELLATIONS OR NO-SHOWS, WE WILL BE UNABLE TO PROVIDE YOU WITH FURTHER SERVICES AT OUR OFFICE.**

We believe this policy is necessary for the benefit of all patients, and allows us to continue to provide the highest quality of treatment for everyone.

Patient Signature_____

Name Printed_____

Date_____

Anthony E. Chillura, DMD;PC
67 Wall Street, Suite 2508
New York, NY 10005
www.wallstdental.com
(212)344-9317

PATIENT FEEDBACK QUESTIONNAIRE

1. Was your initial phone call handled promptly and professionally?

2. Was your appointment time convenient for your schedule?

3. Were you greeted promptly on arrival at our office?

4. Was dental treatment started at the appointed time?

5. Was the treatment to be done at this visit, explained to your satisfaction?

6. Were all financial arrangements and insurance coverage thoroughly explained?

7. Were the doctor and dental assistants on time and professional?

8. Was all the treatment performed done to your complete satisfaction?

9. Were the procedures to be done at your next scheduled appointment, explained to your satisfaction?

10. Were all your needs addressed during your visit?

11. Did you feel as comfortable as possible during your treatment?

12. On a scale of 1-10 (10 being the highest), how would you rate our office?

13. If you had an option to come in on a Monday or Friday, which would be your preference?

14. Any additional comments? (If necessary, use reverse side.)