Parkview Family Dental, PC
Joshua D. Ilan, DDS
18 Thiells Mount Ivy Road, Suite 1
Pomona, NY 10970

ADULT REGISTRATION AND HISTORY

Welcome to our office and thank you for choosing us to help you with your dental health.

Please complete each of the following items.
The information that you provide us is strictly confidential
and will help us know you better and serve you in the best possible way.

PERSONAL INFORMATION

Today's Date_____
Patient's Full Name_____
I prefer to be called_____
Date of Birth_____
E-mail Address_____
Street Address_____
City_____State_____Zip_____
Home Phone No._____
Cell Phone No._____
Name of Employer_____
Present Position_____
Business Address_____
City_____State_____Zip_____
Business Phone No._____
Social Security #_____

Spouse's Name_____
Date of Birth_____
Spouse's Employer_____
Present Position_____
Business Address_____
City_____State_____Zip_____
Business Phone No._____
Social Security #_____
Who is responsible for this account?
❑ Self ❑ Other_____
Whom may we thank for referring you to our office?
_____

Please feel free to discuss any portion of your dental care with our dental team at any time.

INSURANCE INFORMATION

Emergency Contact_____

Do you have dental insurance? ❑ Yes ❑ No

PRIMARY	SECONDARY
Insurance Company_____	Insurance Company_____
Send Claims to (address)_____	Send Claims to (address)_____
_____	_____
_____	_____
Phone No._____	Phone No._____
Insured's Name_____	Insured's Name_____
Relationship to Patient_____	Relationship to Patient_____
Insured's Employer_____	Insured's Employer_____
Insured's Date of Birth_____	Insured's Date of Birth_____
ID #_____	ID #_____
Group #_____	Group #_____

DENTAL HISTORY

YES NO

What prompted you to seek dental care at this time?

_____

_____

Have you ever had any trouble associated with dental treatment? ❑ ❑

Do you have periodic dental check-ups? ❑ ❑

How long has it been since your last thorough dental exam?

How often do you have your teeth cleaned?

How would you describe the condition of your teeth and gums?

❑ Excellent ❑ Good ❑ Fair ❑ Poor

Are you happy with the appearance of your teeth? ❑ ❑

Would you be interested in having whiter teeth? ❑ ❑

Are you concerned about any missing teeth? ❑ ❑

Are you concerned about mouth odor? ❑ ❑

YES NO

Are you aware of clenching or grinding your teeth? ❑ ❑

Do you use dental floss daily? ❑ ❑

Have you ever had any trauma or injury to your teeth? ❑ ❑

Has any dental treatment ever been suggested that was never done? ❑ ❑

If so, please explain_____

_____

Do your gums bleed easily? ❑ ❑

For routine dentistry, do you have novocaine?

❑ Never ❑ Sometimes ❑ Always

Do you have nitrous oxide (laughing gas, sweet air)?

❑ Never ❑ Sometimes ❑ Always

Have you ever had an unusual reaction to dental anesthesia (gas or shots)? ❑ ❑

Do you have any concerns about dry mouth? ❑ ❑

How do you feel about dentistry in general?

❑ ❑ ❑ ❑

If you could change anything about your teeth, what would it be?

_____

_____

_____

_____

It would be helpful if you would indicate below what things you are looking for most in choosing your dentist.

❑ Explains things so that I understand them.
❑ Cares about me.
❑ Is aware of my financial concerns
❑ Has a good appearance.
❑ Has a pleasant staff.
❑ Is gentle when working in my mouth.
❑ Has an attractive office.
❑ Keeps me and my family informed about office happenings and new trends in dentistry.
❑ Is on time for my appointment.
❑ Other

HEALTH HISTORY

Physician's Name_____ Phone No._____

Physician's Address_____ Date of Last Physical Exam_____

YES NO

Please indicate your general physical condition:

❑ Excellent ❑ Good ❑ Fair

Are you being treated for anything now? ❑ ❑

Describe_____

Are you taking any medication now, over the counter or prescription? (including herbal or holistic supplements) ❑ ❑

Describe_____

Have you been hospitalized within the last five years? ❑ ❑

If yes, describe_____

Is your blood pressure: ❑ High ❑ Low ❑ Normal

Are you subject to prolonged bleeding? ❑ ❑

Do you bruise easily? ❑ ❑

Do you wear a pacemaker? ❑ ❑

Have you ever been treated with radiation therapy? ❑ ❑

Did you ever have any of the following?

Diabetes ❑ ❑
Heart Trouble or Heart Murmur ❑ ❑
Mitral Valve Prolapse ❑ ❑
Arrhythmia ❑ ❑
Anemia or Blood Disorder ❑ ❑
Tuberculosis ❑ ❑
Rheumatic Fever ❑ ❑
Sexually Transmitted Disease ❑ ❑
Asthma ❑ ❑
Hepatitis ❑ ❑
Do you use tobacco in any form? ❑ ❑

YES NO

Have you tested positive for HIV virus (AIDS)? ❑ ❑
Ulcers ❑ ❑
Glaucoma ❑ ❑
Kidney Trouble/Dialysis ❑ ❑
Cancer/Chemotherapy ❑ ❑
Organ Transplant ❑ ❑
Lyme Disease ❑ ❑
Lupus ❑ ❑

Are you taking anticoagulants? ❑ ❑

Are you taking Aspirin Therapy? ❑ ❑

Do you have a prosthetic hip, valve or joint? ❑ ❑

Have you been or are you being treated for drug or alcohol dependency? ❑ ❑

Epilepsy? ❑ ❑

Thyroid Problem? ❑ ❑

Emotional Problem or Mental Illness? ❑ ❑

Please add anything you think is important_____

_____

_____

FOR WOMEN ONLY!

Are you taking birth control pills? ❑ ❑

Are you pregnant now? ❑ ❑

When are you due?_____

Name of Obstetrician_____

Obstetrician's Phone No._____

Do you require antibotic medication to have dental treatment? ❑ Yes ❑ No

Are you allergic to any of the following:

❑ Penicillin ❑ Codeine ❑ Novocaine ❑ Iodine ❑ Latex ❑ Acrylic ❑ Sulfa ❑ Tetracycline

Are you allergic to any other drugs? ❑ Yes ❑ No

If so, describe_____

_____

*Patient's Signature*_____*Date*_____

*Doctor's Signature*_____

PAYMENT POLICIES

It is our goal to provide the best possible dental care for our patients. Your financial concerns are important to us. We, therefore, offer the following financial arrangements. We will make every effort to enable you to enjoy the benefits of the best dental care available.

Assignment of Insurance: We understand the value of insurance benefits to our patients and we gladly accept assignment of those benefits. We will do our best to estimate your deductible and the portion that may be covered by your insurance carrier. Please keep in mind that rarely does an insurance company cover an entire fee, and that each carrier sets their own limitations on the maximin amount they will pay for each procedure **based on the type of policy purchased by your employer.** Any balance remaining is your direct responsibility, as are any noncovered charges, deductibles or copayments. It is the policy of our office that you leave a payment at each visit equal to your estimated balance. We do not accept any insurance carrier's fees as payment in full. Since it is impossible for us to be familiar with the details of every insurance plan, we ask that you be aware of your financial responsibilities under the terms of your policy.

Retainers for Treatment Involving Lab Work: We do require a retainer of half the fee for any treatment involving laboratory work. (e.g., crowns, bridges, dentures, nightguards, laminates, etc.)

Courtesy for Payment In Full on Date of Treatment: We are able to pass on the savings of not having to send you a statement if payment in full is made at the time services are rendered. With this payment option, we extend a courtesy of 7% for payment made by cash or check only. With this savings program, there is no assignment of benefits to our office. Payment will be made directly to you by your carrier.

Senior Citizen Courtesy: We do offer a senior citizen courtesy to people age 62 and over of 10% if payment is made by cash or check at the time services are rendered. There will be a 5% courtesy if a credit card is used.

Outside Financing: Our office has contracted with a finance company so that we can offer you several attractive payment options. The qualification process is simple and can usually be completed while you are in our office. You have the choice of making payments over a three, six or twelve month period with 0% financing.

Finance Charge: If your balance with us is not paid in full within 60 days from the monthly billing date, a finance charge will be added to your account for the current monthly billing period. The finance charge will be at a periodic rate of 1.5% per month which is an annual percentage rate of 18%.

Your signature below is evidence that you have read and are aware of our office financial policy.

*Responsible Party's Signature*_____*Date*_____

FOR OFFICE USE ONLY

MEDICAL AND INFORMATIONAL HISTORY UPDATE

Please review your attached Medical History.

Since your last visit, has there been any change in 1) your medical history, 2) medication or pills, 3) have you been seeing a health care practitioner or physician, 4) do you have a change of address, phone number, employer, insurance company, etc.?

Date_____

_____

_____

Signature_____Relationship_____

Date_____

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Signature_____Relationship_____

Date_____

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Signature_____Relationship_____

Date_____

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Signature_____Relationship_____

Date_____

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Signature_____Relationship_____