Complete Family Dentistry

4825 Commercial Drive
New Hartford, NY 13413
(315) 982-9590

Please Print

Patient Name____Sex __________
First Middle Last M/F

Address______________________________City__________State________Zip________

Home Phone______________________________Cell Phone____________________________

Social Security #__________________________Date Of Birth_______________________

If patient is a minor, Parent or Guardian Name__________________________________
First Middle Last

Social Security #______________________________Date Of Birth__________________

Name any other immediate family members

who should be on the same account for billing purposes__________________________

How did you hear of Valley Dental?____

Do you have dental insurance? ☐ Yes ☐ No

	Primary Dental Insurance	Secondary Dental Insurance
Subscriber's Name		
Subscriber's Social		
ID number		
Subscriber's DOB		
Relationship to subscriber		
Subscriber's employer		
Insurance Company		

I authorize Valley Dental to perform the necessary treatment plan. Signature__________________

I have received a copy of the office's Notice of Privacy Practices. Signature__________________

I hereby authorize payment directly to Valley Dental. Signature__________________

Payment Agreement: I understand and agree that dental insurance policies are an arrangement between an insurance carrier and myself. I understand that this office will prepare any necessary forms to assist in making collection from the insurance company, if any, and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are my financial responsibility. I understand and agree that this office, as a courtesy to me, will bill my insurance company, if any, for all services rendered to me. I understand that all co-payments/deductibles are due on the service date and agree to make such payments. I understand that if for any reason my insurance company fails to pay for any service rendered that I am personally responsible for payment and agree to make full payment within 30 days. In the event my account balance is referred to an agency or attorney for collection purposes, I agree to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. In the event that the patient is a minor, I am the parent and/or guardian of said patient and agree that I am responsible for all services rendered to the patient.

Signature____Date_________________________

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Name________________________________Date of Birth________________

List any medications you are taking:______________________________________
____
____

Physician's Name____________________________Physician's Phone________________

Are you allergic to any of the following? (Circle if yes)

Aspirin	Erythromycin	Metals
Codeine	Jewelry	Penicillin
Dental anesthetics	Latex	Tetracycline

For women: Are you

taking birth control
pregnant how many weeks ___________
nursing

Do you smoke/use tobacco?____

Are you required to take an antibiotic premedication?____________________________

Do you or have you had any of the following? (Circle if yes)

Abnormal bleeding	Cancer/chemo	Fever blisters	HIV+/AIDS	Seizures
Alcohol abuse	Colitis	Frequent headache	Kidney prob./dialysis	Shingles
Allergies	Congenital heart defect	Glaucoma	Liver disease	Sickle cell
Anemia	Cosmetic surgery	Hay fever	Low blood pressure	Sinus problems
Angina pectoris	Diabetes	Heart attack	Mitral valve prolapse	Stroke
Arthritis	Difficulty breathing	Heart surgery	Pace maker	Thyroid problems
Artificial bones/joints	Drug abuse	Hemophilia	Pneumocystis	Tuberculosis
Artificial heart	Emphysema	Hepatitis A	Psychiatric prob	Ulcers
Asthma	Epilepsy	Hepatitis B	Radiation therapy	Venereal disease
Blood transfusion	Fainting spells	High blood pressure	Rheumatic fever	Jaundice

List any other conditions/problems not listed above?_____________________________
____

Emergency Contact____________________Phone______________Relationship________________

The above information is accurate to the best of my knowledge.

Patient's signature____Date________________

Initial medical/dental health reviewed by:

Doctor signature____Date________________

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APPOINTMENT CONFIRMATION – CANCELLATION

Confirmation from you for your appointment is required to prevent possible rescheduling or loss of the appointment. Confirmation may be provided via text, email, or phone.

At least 24 hours' notice is required for all cancellations or rescheduling needs. Anyone not providing enough notice will be reminded of the policy. After three (3) missed appointments you may be dismissed from the office.

Signature____Date___________________________________

MESSAGE CONSENT

In order to comply with HIPAA regulation and to maintain patient confidentiality, we need your permission to leave messages regarding appointment, insurance, etc. If we cannot speak with you personally, please check all that apply below:

☐ Leave a message on your answering machine/voice mail.

☐ Leave a message with another person designated by you. The name of that person is: ______________________________________

☐ Ask for and speak only with you.

Signature____Date____________________________

VERBAL INFORMATION RELEASE

We need your permission to give out information concerning appointments you may have with us, any future appointments, or any personal information a caller my request. It is our policy not to release any information regarding your care unless you authorize us to do so. Only the people you list below will be given any information.

Name____Relationship ____________________________

Name____Relationship ____________________________

Name____Relationship ____________________________

I authorize the above people to contact your office to provide or receive information regarding my appointments and/or care at your office.

Signature____Date____________________________