NEW YORK SMILE INSTITUTE
AESTHETIC & IMPLANT DENTISTRY

Dr. Dean Vafiadis **Dr. Alan Smolen** **Dr. Kenneth Young**
Dr. Armen Akopian **Dr. Claudio Franco** **Dr. Alexander Kim**
Dr. Jay Neuhaus **Dr. Louie Khouri** **Dr. Peter Ferro**

Date: _____

Name: _____
Last **First** **MI**

Address: _____ **APT #** _____

City: _____ State: _____ Zip: _____

Telephone: (*Home*): [____]_____(*Work*): [____]_____(*Cell*): [____]_____

E-mail address: _____@_____

Gender: ☐Male ☐Female ☐Other Marital Status: ☐Single ☐Married ☐Divorced ☐Other: _____

Company Name & Address: _____

Occupation: _____

Date of Birth: ____/____/____Age: _____S.S.# _____-____-_____

Referred By: _____

If Internet, which site? _____-

In case of emergency, contact _____ Telephone:_____

Date of last dental examination: _____

Date of last series of complete mouth x-rays: _____

Please complete ALL & Sign (5 pages)

Are you in good health?	Yes	No
Has there been any change in your general health within the past five years?	Yes	No
Do your gums bleed when you brush?	Yes	No
Are you happy with your Smile?	Yes	No
Do you smoke cigarettes, cigars, or pipes?	Yes	No
Are your teeth Yellow?	Yes	No
Would you like to change your Smile?	Yes	No
Whiten your teeth?	Yes	No
Do you have any problem eating certain foods?	Yes	No
Do you have sensitivity to hot or cold foods?	Yes	No
Have you ever been Pre-Medicated with antibiotics before any dental treatment ?	Yes	No
Did you ever have orthodontics?	Yes	No
If yes, how many years_____at what age_____?		
Does your Jaw ever lock opened or closed?	Yes	No
Do your Jaw Joints ever make any noise?	Yes	No
Do you suffer from migraines and/or headaches?	Yes	No
Do you suffer from facial pain?	Yes	No

Please explain your chief complaint and/or your vision of treatment: _____

_____

_____

Please explain any prior dental experiences you may have had that we should be aware about:

_____

_____

List ALL hospitalizations and serious illnesses, including dates:

_____

_____

Have you ever been told to Pre-Medicate prior to receiving Dental Care?

_____

_____

Please check off if you have ever had any of the following:

Diagnosed with a Heart Murmur/Mitral Valve?	☐	Rheumatic Fever or Rheumatic Heart Disease?	☐
Heart attack, angina, or other heart disease?	☐	Prosthetic or Artificial heart valve?	☐
Irregular heartbeat or pacemaker?	☐	Shortness of breathes after mild exercise?	☐
High Blood Pressure?	☐	Swollen Ankles	☐
Asthma, emphysema, or difficulty breathing?	☐	Recent increase in thirst?	☐
Stroke, seizures, or convulsions?	☐	Stomach ulcers or stomach problems?	☐
Diabetes?	☐	AIDS, ARC, HIV infection?	☐
Recent increase in urination?	☐	Arthritis or rheumatism?	☐
Thyroid Problems?	☐	Prosthetic or Artificial joint?	☐
Kidney trouble or Renal Dialysis?	☐	Cancer, radiation treatment, or chemotherapy	☐
Hepatitis, liver disease, or jaundice?	☐	Venereal disease? Syphilis? Gonorrhea?	☐
Tuberculosis?	☐	Persistent cough or coughing up blood?	☐
Psychiatric treatment?	☐	Enlarged lymph nodes or swollen glands?	☐
Autoimmune disease or lupus erythematousus?	☐	Hearing problem or vision problems?	☐
Blood disorder, bleeding tendency or frequent bruising?	☐		

Do you have any allergies? Yes No

If yes, what? _____

Have you ever taken penicillin? Yes No

Have you ever had a bad reaction to any drug or medication? Yes No

If yes, what? ☐Penicillin or other antibiotic ☐Aspirin
☐ Dental anesthetic ☐Codeine or other narcotics
☐Other_____

[WOMEN ONLY] Are you pregnant? Yes No

List all of the drugs or medications you are taking now.

Name of Medication	Dosage	How Long	Reason

Are you under the care of a physician? ☐Yes ☐No

Please provide the MD's name, address and phone number:

_____

_____

_____

In addition to those you have listed, have you taken any of the following medications or drugs within the past year? If yes please check the appropriate box.

☐ ____Medication for asthma	☐ ____Anticoagulants (blood thinners)	☐ ____Cortisone/other steroid
☐ ____Medication for anxiety (nerves)	____Medication for stomach ulcers	☐ ____ Med. for high blood pressure
☐ ____Medication for depression or a disorder	____Cancer, Chemotherapy	____Insulin or pills for diabetes
☐ ____Medication for a heart problem	____Aspirin, arthritis/pain medication	____AZT/other drugs for HIV infection
☐ ____Nitroglycerin or any medication for angina or chest pain	____Methadone maintenance	☐Other: _____

PLEASE INTITAL TO THE LEFT OF EACH STATEMENT BELOW :

_____I understand and authorize New York Smile Institute to take all diagnostic materials needed to make a final diagnosis of dental treatment. Diagnostic materials may include Intra-oral pictures, radiographs, digital radiographs, diagnostic models, photographs and slides. This material may be used for lectures, articles and or publications. This information may also be shared with any dental laboratory

_____I authorize New York Smile Institute to perform and or administer any and all forms of treatment, medication and anesthesia that may be necessary.

_____ I authorize WEAVE Patient Communications, and New York Smile Institute to contact me via the phone numbers, and e-mail I have listed for all communications regarding appointments, treatment, and/or balances due.

_____I will assume responsibility of notifying The New York Smile Institute of any changes in my medical history, insurance policy or contact information.

_____I understand that The New York Smile Institute reserve the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

We reserve the right to charge our patients a fee for appointments that are broken or not cancelled with 24 hour notice.

Hygiene Cancellation Fee : $ 95.00

Doctor Cancellation Fee : $ 150.00

Patient's Signature: _____ Date: _____

NEW YORK SMILE INSTITUTE

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FINANCIAL POLICY

Our practice is committed to providing the best treatment for our patients using the highest quality of materials, labs, instruments and latest digital technology. New York Smile Institute continually invests in the continuing education of our doctors, hygienists and fellow team members in order to provide you, our valued patient with options to reach your dental needs.

_____ *I understand that it is my responsibility to inquire about fee's for treatment prior to providing consent.*

_____ *I understand any dental treatment provided to me is my financial responsibility and that all fees for services are due and payable up front, and/or installments can be made. Balance is due in full however prior to completion of treatment provided.*

_____*Payment is expected at the time services are provided unless prior financial arrangements have been made.*

INSURANCE:

New York Smile Institute is out of network. As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.

Patient Name _____

Patient's Signature:_____ **Date**:_____

Dental Insurance Plan _____

Member ID _____Group # _____

Dental Claim Mailing Address _____

_____

_____

_____

Provider Contact Phone # _____