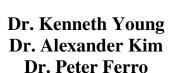
## NEW YORK SMILE INSTITUTE





Dr. Alan Smolen Dr. Claudio Franco Dr. Louie Khouri



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

Are you pregnant?

Yes

No

[WOMEN ONLY]

List all of the drugs or medications you are taking now.						
Name of Medication	<u>Dosage</u>	How Long	Reason			
Are you under the care of a p	ohysician? ∐Ye	es [No				
Please provide the MD's nan	ne, address an	d phone number:				
In addition to those you have listed or drugs within the past year? If y						
Medication for asthma	: 	Anticoagulants (blood th	inners) †Cortisone/other steroid			
☐Medication for anxiety (nerves)		Medication for stomac	h ulcers $\ \square$ Med. for high blood pressure			
Medication for depression or a disc	order	_Cancer, Chemotherap				
☐Medication for a heart problem ☐Nitroglycerin or any medication for angina or chest pain		Aspirin, arthritis/pain n Methadone maintenan	nedicationAZT/other drugs for HIV infection ce    Other:			
publications. This information may al	so be shared w	vith any dental laborat	ey be used for lectures, articles and or cory ser any and all forms of treatment,			
medication and anesthesia that may	be fiecessary.					
			e Institute to contact me via the phone ntments, treatment, and/or balances due.			
I will assume responsibilithistory, insurance policy or contact in		he New York Smile Ins	stitute of any changes in my medical			
	es regarding al	I protected health info	to change the terms of its Notice of ormation resident at, or controlled by, this by Practices on request.			
We reserve the right to charge our panotice.	atients a fee fo	or appointments that a	re broken or not cancelled with 24 hour			
	Hygiene Ca	ancellation Fee : \$ 95.0	00			
	Doctor Car	ncellation Fee : \$ 150.0	00			
Patient's Signature:			Date:			

## NEW YORK SMILE INSTITUTE

## **AESTHETIC & IMPLANT DENTISTRY**

## 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: Dental Insurance Plan \_\_\_\_\_\_Group # \_\_\_\_\_ Member ID Dental Claim Mailing Address Provider Contact Phone # \_\_\_\_\_\_