

Welcome To Your New Dental Home!

Dr. Homa Ameri

Address: 809 Rt. 25A Rocky Point NY 11778

Phone: 631-744-3700

Email: Rockypointfamilydentistry@yahoo.com

Website: Rockypointfamilydentistry@.net.com

Date _____

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Social Security # _____ Date Of Birth _____

Home Number _____ Cell Number _____

Email Address _____

Sex: (male,female) _____ Marital Status: (married,single,child,other) _____

We would like to thank who referred you _____

Dental Insurance Information

Information of the Insured:

First Name _____ Last Name _____

Social Security # _____ Date Of Birth _____

Insurance Company _____

Relationship To You _____ Employer _____

Name Of Secondary _____

Patient Signature _____

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Date: _____

Dental Insurance Information

Primary Dental Insurance Company:

Insurance Company Name _____

Insurance Company Address _____

Insurance Company Phone # _____ Subscriber ID # _____

Subscriber Name _____ Date Of Birth ____/____/____ Employer _____

Family Members Under Plan _____

Local or Group # _____

Assignment Of Benefits

I authorize payment of benefits to Dr. Ameri
for dental services provided.

Signature

Release Of Information

I authorize the release of any dental information
necessary to process claims.

Signature

Secondary Dental Insurance Company:

Insurance Company Name _____

Insurance Company Address _____

Insurance Company Phone # _____ Subscriber ID # _____

Subscriber Name _____ Date Of Birth ____/____/____ Employer _____

Family Members Under Plan _____

Local or Group # _____

Assignment Of Benefits

I authorize payment of benefits to Dr. Ameri
for dental services provided.

Signature

Release Of Information

I authorize the release of any dental information
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Signature

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Patient Medical History

Physician _____ Office Phone # _____ Date Of Last Exam _____

1.) Are you under medical treatment now ? _____ If Yes, Please Explain

2.) Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? _____
If Yes, Please Explain

3.) Please list all the medications you are currently taking, including non-prescription medicine:

4.) Do you use any tobacco products? _____ 5.) Do you use controlled substances ? _____

6.) Are you taking any blood thinners? _____

7.) Do you have a persistent cough/throat clearing not associated with a known illness _____

8.) Are you allergic to or have you had any reactions to the following:

Local Anesthetics (Novocaine) Yes _____ No _____

Penicillin or any other antibiotics Yes _____ No _____

Sulfa Drugs Yes _____ No _____

Barbiturates Yes _____ No _____

Sedatives Yes _____ No _____

Iodine Yes _____ No _____

Aspirin Yes _____ No _____

Any Metals (nickel,mercury,etc) Yes _____ No _____

Latex Rubber Yes _____ No _____

Other: _____

Women Only:

1.)Are you pregnant or think you might be? _____ 2.)Are you nursing? _____ 3.)Are you taking oral contraceptives_____

Patient Signature _____ Date _____

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Patient Medical History

Do you have any of the following ?

	Yes	No		Yes	No		Yes	No
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Problems/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Aids or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement/Implant	<input type="checkbox"/>	<input type="checkbox"/>						
Sexually Transmitted Disease	Yes _____	No _____	Other	_____				

Patient Dental History

Previous Dentist _____ Location _____ Phone _____

- 1.) Do your gums bleed while brushing /flossing? Yes _____ No _____
- 2.) Are your teeth sensitive to hot/cold liquids or foods? Yes _____ No _____
- 3.) Are your teeth sensitive to sweet/sour liquids or foods? Yes _____ No _____
- 4.) Do you feel any pain in your teeth ? Yes _____ No _____
- 5.) Do you have any sores or lumps in or near your mouth? Yes _____ No _____
- 6.) Have you had any head, neck or jaw injuries? Yes _____ No _____
- 7.) Have you experienced any of the following problems in your jaw?
Clicking? Yes _____ No _____ Pain/Difficulty opening/closing mouth? Yes _____ No _____
- 8.) Do you have frequent headaches? Yes _____ No _____
- 9.) Do you clench or grind your teeth? Yes _____ No _____
- 10.) Do you bite your lips or cheeks frequently? Yes _____ No _____
- 11.) Have you had any orthodontic treatment? Yes _____ No _____
- 12.) Have you had any difficulty with extractions/prolonged bleeding following extractions in the past?
Yes _____ No _____
- 13.) Do you wear dentures or partials? Yes _____ No _____ If so, date of placement _____
- 14.) Do you like your smile? Yes _____ No _____

Patient Signature _____ Date _____

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Patient Consent Form

I understand that I Have certain rights to privacy regarding my protected health information. These rights are given to me under the health insurance portability and accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you use and disclose my protected health information to carry out:

- Treatment / direct or indirect treatment also by other Healthcare Providers
- Obtaining payment from third party payers (example - Insurance Companies)
- The day-to-day Healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your notice of privacy practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payments, and Healthcare operations And that you are not required to agree to these requested restrictions. However if you do agree, you are then bond to comply with this restriction.

I also understand that I may revoke this consent, in writing, at any time. However any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name _____ Date _____

Signature _____ Relationship To Patient _____

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Medical Information Release Form (HIPPA Release Form)

Name _____

Date of Birth ____/____/____

Release of Information:

I Authorize the release of information including the diagnosis, records, examination results, medication dose changes, and claims information.

The information may be released to:

Spouse _____

Children _____

Other _____

Information is not to be released to anyone other than me

Messages:

Please call my home phone _____ my cell phone _____

If unable to reach me:

you may leave a detailed message **or** leave me a message to return your call only

The best time to reach me is (day(s) of week) _____ between (time) _____

Email Messages:

I give you permission to email me to contact you only

I give permission to email me a detailed message, including future appointment details

My email address is _____

Text Messaging:

I give you permission to text me to contact you only

I give you permission to text me a detailed message, including future appointment details

My cell number is _____

Patient Signature _____ Date _____

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E-Prescribing Consent Form

Patients Name _____ Date of Birth _____

Rocky Point Family Dentistry is In the process of implementing e-prescribe (electronic prescribing) in our ongoing efforts to maximize patient safety.

Patient Benefits:

- Less confusion over handwritten prescriptions/unclear phone calls
- Reduced possibility of medical errors
- Fewer trips to drop off at the pharmacy
- Less chance of adverse drug reactions
- A safer, faster and easier way to get your prescriptions filled

Please list any DRUG allergies:

_____	_____
_____	_____
_____	_____

Please provide our office with your Pharmacy name, address and phone number so that we may enter the data into your dental record.

Pharmacy Name _____ Pharmacy # _____

Pharmacy Address _____

I agree that Rocky Point Family Dental may request and use my prescription medication history from other Healthcare Providers or third-party Pharmacy benefit payers for treatment purposes.

Patient Signature _____

Date ____/____/____

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Financial Policies Supplement

Please initial that you acknowledge and agree to abide by our policies:

The practice accepts personal checks and credit cards for copayments and deductibles. In the event that a check bounces due to insufficient funds, the practice will apply a \$25 additional fee to your account. _____

Patients are responsible for all balances that is not covered by their insurance policy. _____

Failure to settle balances in a timely manner may result in retention of collection agencies and may result in a report to the credit bureau which may affect your ability to obtain Credit in the future. _____

All patients receive a courtesy call for upcoming appointments. Failure to appear to your appointment (no show) without a 24 hour cancellation will result in a \$75 fee. _____

By signing below, I acknowledge and agree to abide by this policy:

Patient Name _____

Patient Signature _____ Date: _____

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Covid 19: Screening Checklist

Patient Name: _____ DOB _____

Do you or have you been diagnosed with Covid 19? _____ If so, how long were you quarantined? _____

Have you had contact with anyone diagnosed with Covid 19 in the past month? _____

Do you have any of the following respiratory symptoms:

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Muscle pain |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Repeated shaking with chills | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> New loss of taste or smell | |

Temperature _____

Fever Present

Have you worked in facilities or locations with recognized Covid-19 cases? _____

We require each patient to wear a mask, gloves and booties over shoes upon entry into our building. In addition, to wash hands or use an alcohol-based hand sanitizer.

Patient Signature _____ Date _____

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