Central Park West Dentistry

Phone: (212) 579-8885
Fax: (212) 579-8881
Text: (646) 681-4146
office@cpwdentistry.com

25 West 68th Street, Suite 1A
25 Central Park West, Suite 1B
New York, NY 10023
www.cpwdentistry.com

Patient Form and Health History

We are pleased to welcome you to our practice!
Please complete, print, and sign these forms and bring them with you to your appointment.
Feel free to call us at **212-579-8885** if you have questions.

Patient Information

Date (MM/DD/YR) _____

Name (LAST, FIRST, MIDDLE INITIAL) _____ Social Security #_____

Preferred Name_____

Gender _____ Birthdate (MM/DD/YR)_____ ❑ Married ❑ Single ❑ Minor ❑ Partnered ❑ Other

Address (STREET, CITY, STATE, ZIP)_____

Email Address _____

Home Phone #_____ Cell Phone # _____ Work # _____

We'll send you treatment, scheduling, and financial information via a variety of ways including phone calls, emails, and text messages.
If you do *not* wish to be contacted via any of these methods, please let us know and we'll be happy to update your preferences.

How did you find out about our office? _____
If you were referred by a friend, please let us know their name so we can thank them.

In case of emergency, who should be notified? Name_____ Phone # _____

Patient Occupation_____

Patient Employer/School _____

What's one fun thing you'd like us to know about you? _____

Primary Insurance

Name of Subscriber (LAST, FIRST, MIDDLE INITIAL)_____

Relation to Patient: ❑ Self _____ ❑Other _____ Birthdate (MM/DD/YR) _____

Insurance Company Name_____ Insurance Company's Phone # _____

Subscriber ID # _____ Group #_____

Do you have a secondary dental insurance? _____

Insurance Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____
(name of insurance carrier(s) and assign directly to Central Park West Dentistry, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Central Park West Dentistry may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____ _____

Signature (Patient, Parent, Guardian or Personal Representative) | Relationship to patient | Date (MM/DD/YR)

CPW DENTISTRY

Patient Form and Health History (continued)

(Continued) **Patient Name:** _____ Date _____

Dental History

Former Dentist (NAME, CITY) _____

Please check if you have any of the following:

- ❑ Breath has an odor
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ Grinding teeth
- ❑ Loose tooth or broken fillings
- ❑ Periodontal disease
- ❑ Sensitivity to cold
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in mouth

What's your favorite thing about your smile: _____

Would you like to change anything about your smile? _____

Do you have any special preferences you'd like us to be aware of? _____

Are you interested in learning about our anxiety relief options if you require any treatment? ❑ Yes ❑ No

Do you participate in any sports or martial arts activities? ❑ Yes, _____ ❑ No

Medical History

Physician's Name (NAME, CITY)_____ Date of last visit _____

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, give approximate date(s) _____

How are you feeling today? _____

Are you receiving or have you ever received/taken Bisphosphonates? ❑ Yes ❑ No

WOMEN: Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Check if you have or have had any of the following:

- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial heart valves
- ❑ Artificial joints
- ❑ Asthma
- ❑ Back problems
- ❑ Blood disease
- ❑ Cancer
- ❑ Chemical dependency
- ❑ Chemotherapy
- ❑ Circulatory problems
- ❑ Cortisone treatments
- ❑ Cough, persistent
- ❑ Cough up blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart murmur
- ❑ Heart problems
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ HIV/AIDS
- ❑ HPV
- ❑ Kidney disease
- ❑ Jaw pain
- ❑ Liver disease
- ❑ Mitral valve prolapse
- ❑ Tattoos/Piercings
- ❑ Pacemaker
- ❑ Radiation treatment
- ❑ Respiratory disease
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Shortness of breath
- ❑ Skin rash
- ❑ Sleep apnea
- ❑ Stroke
- ❑ Swelling of feet or ankles
- ❑ Thyroid problems
- ❑ Tobacco habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Sexually transmitted infection

Have you had any illnesses or operations we should know about? ❑ Yes ❑ No

If yes, please describe_____

Medications

Preferred pharmacy name, zip code, & phone number: _____

Please list any medications you are currently taking: _____

_____

Please list any allergies: _____

Authorization: I certify that the information I have provided is correct to the best of my ability

_____ _____ _____

Signature (Patient, Parent, Guardian or Personal Representative) Relationship to patient Date (MM/DD/YR)

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Central Park West Dentistry Office Policies

IF YOU NEED TO RESCHEDULE

Please be Conscientious with Your Appointments

- Our clinical team reserves each appointment just for you and we don't over book, so it's important that you're on time.
- We understand that life happens, but if you do need to change your appointment please let us know at least **48 hours** in advance.
- Appointments that are cancelled less than 48 hours in advance will be subject to a cancellation donation of $75.00 *per hour* of time reserved.
- 100% of these broken appointment fees are donated to one of the following nonprofit organizations.
  Please Select Your Preference:
  ❑ St. Jude Children's Research Hospital
  ❑ American Society for the Prevention of Cruelty to Animals (ASPCA)
  ❑ Doctors without Borders
- We will make every effort to contact you to confirm your appointment well in advance, however if you have not responded to confirm, we may need to give your appointment to another patient with a dental need.

PAYMENT ARRANGEMENTS

Payment is Expected the Day Service is Rendered

- We accept Visa, MasterCard, Discover, American Express, cash, certified check, and Care Credit.
- We offer payment plans and interest-free financing for approved patients through The Lending Club and Care Credit.

We Submit Insurance Claims as a courtesy to all our patients, however, any portion that the insurance does not cover is the patient's responsibility. We want to help you understand your insurance and maximize your benefits, but also we want to make sure you're aware insurance coverage isn't a guarantee of payment. If for any reason your insurance does not pay us what was estimated, the responsibility for payment will be yours.

- We accept most major PPO plans towards payment. Your estimated out of pocket responsibility is due at time of your treatment.
- We have general dentists who are contracted with Delta Dental Premier, Cigna DPPO, and Aetna PPO plans. We are considered out-of-network for all other insurance carriers. Our specialists are not contracted as in-network providers with any plans, but you can still use your insurance to help with the cost of care at the time of your visit.
- Refunds are issued by check. Please allow 1-2 weeks after insurance payment for any credits to be issued as a refund.

OUR HONOR CODE

Honor Yourself: Take a moment to honor yourself. You've set aside time today to look after your health and wellbeing; for that alone you deserve a round of applause. Our entire team is grateful for the opportunity to help you. We've designed an experience to give you freedom to express your wellness goals without shame. It's by honoring your unique story, whatever it may be, that we can truly get to know you and your needs. We simply ask for honesty, and we'll do everything we can to help you reach your goals.

Honor Your Word: The choices you make in treatment are commitments to yourself and your caregivers. When you choose an appointment time, we ask that you respect the time that is reserved just for you. Please arrive on time so we can give you the quality care that we've promised. When you choose a financial package, please stick with the agreements you've made so that your treatment timeline isn't compromised. Remember that treatment is important for your wellness. If you're using insurance and it doesn't pay quite what we estimated, we have several flexible financial options for you to help manage the cost of your care, because ultimately your health is the most important thing!

Honor Each Other: You deserve to receive care in a tranquil and pleasant environment, so we ask that you help maintain a positive atmosphere. Please be conscious of your behavior and avoid acting in ways that could negatively affect other patients or caregivers. We're all in this together!

Patient acknowledgment:_____
Type/Print Patient Name

_____ _____ _____
Signature (Patient, Parent, Guardian or Personal Representative) | Relationship to patient | Date (MM/DD/YR)

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HIPAA Policy

Central Park West Dentistry

Notice of Privacy Practices: Use and Disclosure of Health Information Protected under HIPAA

Effective May 1, 2014

This document provides a summary of how health care information about you may be used and disclosed and how you can obtain access to this information.

We understand that information about you and your health is personal. We are committed to protecting your health information. It is our policy that the privacy of your protected health information (PHI) not be compromised while still allowing necessary access to assure that the health care you receive is appropriate and of the highest possible quality.

We pledge to you that we will protect the confidentiality of information provided to us. Your information will be used in the following manner, known as Treatment, Payment, and Healthcare Operations (TPO):

1. To provide dental treatment and/or services.
2. To facilitate payment by third party payers, when appropriate, for health care treatment you receive.
3. To facilitate the mechanisms which allow the operation of our facility.

In every use of your information, we will be responsible custodians of your PHI and adhere to the standards set forth in the legislation, which created these privacy practices. We recognize that all patients have the right to privacy in matters relating to their health, and we will not use your PHI for uses other than TPO related to health care without your express permission.

You have the following rights regarding the medical information we maintain about you:

1. Access, upon request, to information that may be used to make decisions about your care.
2. To request restrictions or limitations on the PHI we disclose about you for treatment, payment or health operations. While we are not required to agree to your request, if we do agree, we will comply with the restrictions unless the information is needed to provide emergency treatment.
3. To request that we amend the PHI we maintain about you if you believe that the information we have about you is incorrect or incomplete.
4. To request an accounting of disclosures we have made for uses other than our own.
5. To request confidential communications; i.e., that we communicate with you in a certain manner or at a certain location.
6. To receive a paper copy of this notice.

All members of our staff are committed to adhering to the conditions set forth in this notice of privacy practices. Any violation will be grounds for disciplinary action. We reserve the right to change this policy in the future; such changes will be available to all patients.

Authorized Disclosures: Central Park West Dentistry will not use or disclose your PHI without your prior authorization. You can later revoke that authorization in writing to allow any future use and disclosure. The authorization will be obtained from you by Central Park West Dentistry.

Should you believe that your privacy rights have been violated, you may file a complaint with this facility or with the State oversight department; all complaints must be submitted in writing. You will not be penalized for filing a complaint.

Central Park West Dentistry may disclose information regarding my treatment and financials to the following person(s):

_____

Patient acknowledgment: I acknowledge receipt of this information regarding my right to PHI privacy

_____ _____ _____

Signature (Patient, Parent, Guardian or Personal Representative) | Relationship to patient | Date (MM/DD/YR)

No Expiration Until Required by Law

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Consent Form for General Dental Procedures

As part of your healthcare team, we want to be honest and informative. We're giving you this form to start things out on the right foot…

We believe in empowered patients, making informed decisions. You have the right to accept or reject any dental treatment we recommend. Please don't consent to treatment until you've discussed potential benefits, risks, and complications with us. We'll take the all the time you need to answer your questions, so please speak up if you have any. By consenting to treatment, you acknowledge that you accept the possibility of risks and complications, no matter how unlikely. Some possible, but uncommon, risks of treatment include, but are not limited to: pain, swelling, or discomfort; infection in need of medication or other treatment; numbness, pain, tingling or an altered sensation in your lip, face, chin, gums or tongue; loss of taste; damage to adjacent teeth, prior restorations (like crowns), or gums; deterioration of condition which could result in tooth loss; the need for replacement of restorations, implants, or other appliances in the future; an altered bite in need of adjustment; injury to the jaw joint or jaw fracture requiring follow-up care; a root tip, bone fragment, or separated dental instrument left in the body and requiring removal at a later time if symptoms develop; sinus infection or opening between the mouth and sinus cavity resulting in infection or need for further treatment; allergic reaction to anesthetic or medication. We know that's a lot, but we wanted to tell you just in case. Our providers are at the top of their field and will do everything they can to avoid any of these already unlikely complications. We're on your side!

It's important that you follow our advice regarding medication, pre and post treatment instructions and referrals to specialists. Please return for all of your scheduled appointments and follow ups. We don't like being bossy, but we have to say it: if you don't follow our advice, you could increase your chances of a poor outcome, and no one wants that.

It is imperative that you provide us with accurate information before, during and after your treatment. Certain medical conditions can create a risk of serious complications. If you have a heart condition or heart murmur, please tell us so we can consult with your physician if necessary. Every time we see you, it's important you let us know about any new medicines you're taking or any changes to your health history. Please also be sure to provide us with an accurate list of any drug allergies you have.

You are an important part of the treatment team. Please report any problems or complications you experience. If a procedure that was originally done at Central Park West Dentistry needs to be redone, in many cases we will redo it at no cost to you as long as you have been coming to see us for your regular dental wellness visits and following all of our instructions.

You are entering into a relationship with Central Park West Dentistry for professional care. Meritless and frivolous claims for dental malpractice have an adverse effect on the cost and availability of care. As additional consideration for professional care provided by Central Park West Dentistry, you agree not to advance any false, meritless, or frivolous claim of malpractice.

Please don't sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Be certain all of your concerns have been addressed to your satisfaction before commencing treatment. Never hesitate to ask us questions, that's what we're here for!

Patient acknowledgment:

_____

Type/Print Patient Name

_____ _____ _____

Signature (Patient, Parent, Guardian or Personal Representative) | Relationship to patient | Date (MM/DD/YR)