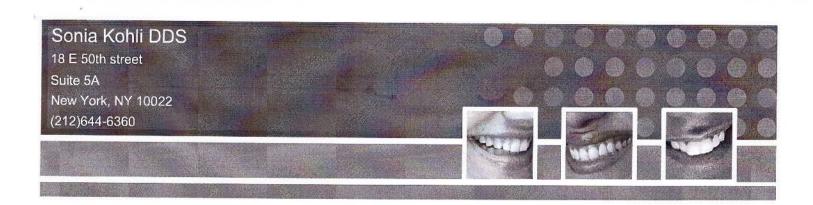


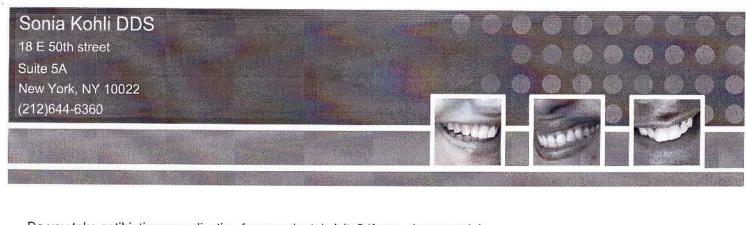
# Welcome to our Practice

	Chart #.	
	FOR OF	FICE USE ONLY
Patient Name:		
Last First	MI Preferre	ed Name
Title: Gender: Male Female Family Status: Marr	ried O Single O	Child Other
Birth Date: SS #.	Prev. Visit:	
Email Address:	Best time to call:	
Phone:		
Home Work Ext Mobile	Fax	Other
Address:		
	L	Zip Code
City  The following is for: the patient the person responsible for paymen		
Employer Name:	Phone:	
Address:		
		7.01
City  Whom may we thank for referring you to our practice?	State	Zip Code
In an emergency who should be notified? Please enter Name and Phone number	below:	



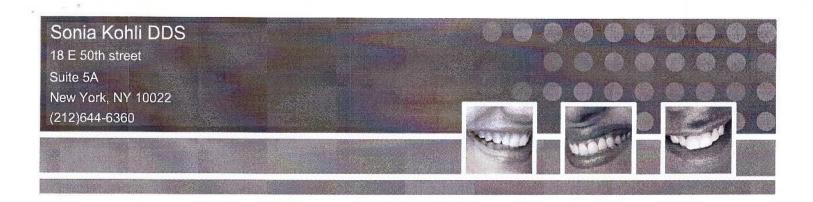
## **Medical History**

Indicate which of the following blank will indicate		nave at present. By checking	ng the box it will indicate a "Yes" response						
*Pre-Med - Amox	*Pre-Med - Clind	*Pre-Med - Other	Allergies						
Allergy - Aspirin	Allergy - Codeine	Allergy - Erythro	Allergy - Hay Fever						
Allergy - Latex	Allergy - Other	Allergy - Penicillin	Allergy - Sulfa						
Anemia	Arthritis	Artificial Joints	Asthma						
Blood Disease	Cancer	Diabetes	Dizziness						
Epilepsy	Excessive Bleeding	Fainting	Glaucoma						
Head Injuries	Heart Disease	Heart Murmur	Hepatitis						
High Blood Pressure	HIV	Jaundice	Kidney Disease						
Liver Disease	Mental Disorders	Nervous Disorders	Other						
Pacemaker	Pregnancy	Radiation Treatment	Respiratory Problems						
Rheumatic Fever	Rheumatism	Sinus Problems	Stomach Problems						
Stroke	Tuberculosis	Tumors	Ulcers						
Venereal Disease									
Ever been hospitalized	d (illness or injury)	Presently being	treated for any other illnesses						
Taking medication for	weight control (ie fen-phe	n) Taking dietary su	upplements						
Subject to frequent he	Subject to frequent headaches  A smoker or smoked previously								
FEMALE: Taking birth control pills FEMALE: Pregnant									
If any conditions or alerts selected above needs further clarification, please describe below:									
		, ,							



Do you take antibiotic premedication for your dental visits? If yes, please explain.
Name of physician and their specialty:
Most recent physical exam and purpose:
Describe any current medical treatment, impending surgery, or other treatment that may possibly affect you dental treatment.
List all medications, supplements, and/or vitamins taken within the last two years:
By checking this box, I acknowledge that above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.
Dental Information
How would you rate the condition of your mouth?  Excellent Good Fair Poor  Previous Dentist name and how long have you been a patient there:
Date of most recent dental exam:
Date of most recent dental x-rays:
I routinely see my dentist every:

Sonia Kohli DDS 18 E 50th street Suite 5A New York, NY 10022 (212)644-6360						
3 mo.	4 mo.	6 mo.	12 mo.	Not routinely	/	N. 1975 Pagal
What is your immediate	concern?		75			
				mentageniseless and the extension	<del>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</del>	
Personal History, Check	all that apply:					
Had an unfavorable of	dental experience		Had complications from p	ast dental treatme	nt	
Had trouble getting n	umb		Had any reactions to loca	l anesthetic		
Had/have braces, ort	hodontic treatmer	nt	Had your bite adjusted			
Had any teeth remov	ed					
If any of the checked bo	xes need further	explanation	, please describe:			



### Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

Ву	checking	this	box,	l understand	the	above	information	and	agree	with	its	contents,	and	this	will	serve	as	my
ele	ectronic sig	natu	re for	the Administra	ation	Form.												

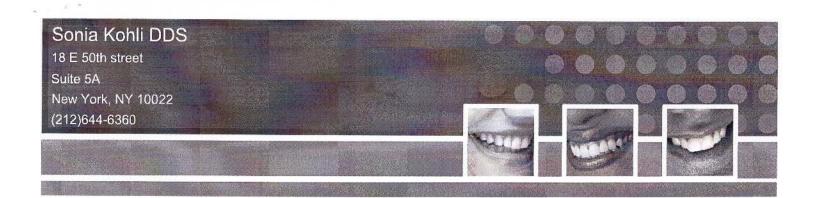
#### **HIPAA Acknowledgement**

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

Ву	checking	this	box, I	understand	the	above	information	and	agree	with	its	contents,	and	this	will	serve	as	my
ele	ctronic sig	natur	e for the	he HIPAA Di	sclos	sure Fo	rm.											



### **Consent for Internet Communications**

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured practice, and grant the dental practice permission to secu	uploading of patient information to the web site for the dental rely upload my patient information to the web site.
Signature of patient, parent or guardian:	
Signature:	Date:
Relationship to patient:	
	Response Date:

