3D Dental
Dr. Eran Arvilli DDS
1636 Montauk Hwy. Suite #3 Mastic, New York 11953
631-772-7379

Welcome

Patient Registration Form

Patient's Name:_____ Date:_____
Last First Middle Initial

Address: _____

City:_____ State:_____ Zip: _____

Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____

_____

Employment Information:

Name of Employer: _____

Employer Address: _____

Present Position:_____ How long: (years)_____(months)_____

Dental Insurance Name:_____ Group #:_____ Local #:_____

Insurance Address: _____

Social Security Number:_____ Date of Birth:_____ Driver's Lic.#: _____

MARITAL STATUS: □ Single □ Married □ Widowed □ Other _____

Dental Information

1. How long has it been since your last dental visit?

   □ Less than 6 months □ 6 months □ 1 year □ 2 years □ Over 2 years

2. Why did you leave your last dentist?

   □ I moved □ Did not have my interests in mind □ I had financial problems within the office

   □ The dentist moved □ Did not explain things □ Unresolved problems with office

   □ I always had to wait □ Was not gentle □ Prefer not to say

   □ Inconvenient hours □ Office staff was uncaring

Health History

Name_____ Home Phone_____Business Phone_____
Address_____City_____State_____Zip code_____
Occupation_____Height_____Weight_____ Date of Birth ___/___/____Sex ☐ M ☐ F
Emergency Contact_____ Relationship_____ Phone (____)_____
If you are completing this form for another person, what is your relationship to that person? _____
Name Relationship

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please not that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Dental Information

Yes	No	Don't Know		Yes	No	Don't Know	
☐	☐	☐	Do your gums bleed when you brush?	☐	☐	☐	Have you ever had orthodontic (braces) treatment?
☐	☐	☐	Have you had any periodontal (gum) treatments?	☐	☐	☐	Do you have headaches, earaches or neck pains?
☐	☐	☐	Do you wear removable dental appliances?	☐	☐	☐	Are your teeth sensitive to cold, hot, sweets or pressure?

☐ ☐ ☐ Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain
_____
How would you describe your current dental problem? _____
Date of your last dental exam_____Date of last dental X-Ray _____
What was done at that time? _____
How do you feel about the appearance of your teeth? _____

Medical Information

Yes	No	Don't Know	
☐	☐	☐	Are you in good health?
☐	☐	☐	Has there been any change in your general health within the past year? Do you have any of the following diseases or problems:
☐	☐	☐	Active Tuberculosis
☐	☐	☐	Persistent cough greater than a 3 week duration
☐	☐	☐	Cough that produced blood
☐	☐	☐	Are you under the care of a physician? If so, what is /are the condition(s) being treated? _____

Physician(s)_____
Name Phone Address

☐ ☐☐ Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem?
_____

☐ ☐ ☐ Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If so, what medicine(s) are you taking? _____

☐ ☐ ☐ Are you taking, or have you taken, any diet drugs such as Pondimin (fendiuramine), Reduz (dexphenfluramine) or phen-fen(Phentermine)?

☐ ☐ ☐ Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours?_____In the past month? _____
If yes,_____# of drinks per day for_____ # of years

☐ ☐ ☐ Are you alcohol and/or drug dependent? If so, have you received treatment? (Check one) ☐ Yes ☐ No

☐ ☐ ☐ Do you use drugs or other substances for recreational purposes? If yes, please list_____
Frequency of use (daily, weekly, etc.)_____ Number of years of recreational drug use_____

☐ ☐ ☐ Do you use tobacco (smoking, snuff, chew)? If so, how interested are you in stopping? (Check one) ☐ Very ☐ Somewhat ☐ Not

☐ ☐ ☐ Do you wear contact lenses?

Allergies – Are you allergic to or have you had a reaction to: (please fill out both columns)

Yes	No	Don't Know		Yes	No	Don't Know	
☐	☐	☐	Local anesthetics	☐	☐	☐	Latex
☐	☐	☐	Aspirin	☐	☐	☐	Iodine
☐	☐	☐	Penicillin or other antibiotics	☐	☐	☐	Hay fever/seasonal
☐	☐	☐	Barbiturates, sedatives, or sleeping pills	☐	☐	☐	Animals
☐	☐	☐	Sulfa drugs	☐	☐	☐	Food (Specify)_____
☐	☐	☐	Codeine or other narcotics	☐	☐	☐	Other (Specify)

To yes responses, specify type of reaction _____

Yes No Don't Know

- ☐ ☐ ☐ Are you pregnant?
- ☐ ☐ ☐ Nursing?
- ☐ ☐ ☐ Taking birth control pills?
- ☐ ☐ ☐ Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so, when was this operation done? _____
- ☐ ☐ ☐ Have you ever had any complications or difficulties with your orthopedic joint?

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, what antibiotic and dose, and what reason?_____

Name of physician or dentist*_____Phone _____

Please (x) if you have or had any of the following diseases or problems.

Yes	No	Don't Know		Yes	No	Don't Know		Yes	No	Don't Know	
☐	☐	☐	Abnormal bleeding	☐	☐	☐	Disease, drug or radiation	☐	☐	☐	Neurological disorders
☐	☐	☐	AIDS or HIV induced immunosuppression				If yes, specify _____				
☐	☐	☐	Anemia	☐	☐	☐	Diabetes, if yes specify type	☐	☐	☐	Osteoporosis
☐	☐	☐	Arthritis	☐	☐	☐	Dry mouth	☐	☐	☐	Persistent swollen glands in neck
☐	☐	☐	Rheumatoid arthritis	☐	☐	☐	Eating disorder	☐	☐	☐	Respiratory problems
☐	☐	☐	Asthma	☐	☐	☐	Epilepsy	☐	☐	☐	Severe headaches
☐	☐	☐	Blood Transfusion	☐	☐	☐	Fainting spells or seizures	☐	☐	☐	Severe or rapid weight loss
			If yes, date_____	☐	☐	☐	G.E. reflux	☐	☐	☐	Sexually transmitted diseases
☐	☐	☐	Cancer/chemotherapy	☐	☐	☐	Glaucoma	☐	☐	☐	Sinus trouble
			Radiation treatment	☐	☐	☐	Hemophilia	☐	☐	☐	Sleep disorder
☐	☐	☐	Cardiovascular disease	☐	☐	☐	Hepatitis, jaundice or liver disease	☐	☐	☐	Sores or ulcers in the mouth
			If yes, specify	☐	☐	☐	Recurrent infections	☐	☐	☐	Stroke
			O Angina				Indicate type of infection	☐	☐	☐	Systemic lupus erythematosus
			O Arteriosclerosis				_____	☐	☐	☐	Thyroid problems
			O Artificial heart valve	☐	☐	☐	Kidney problems	☐	☐	☐	Tuberculosis
			O Coronary insufficient	☐	☐	☐	Low blood pressure	☐	☐	☐	Ulcers
			O Damages heart valves	☐	☐	☐	Mental health disorders	☐	☐	☐	Excessive urination
			O Heart attack				If yes, specify below:	☐	☐	☐	Do you have any disease, conditions, or problem not listed above that you think I should know about? Please explain:
			O Heart murmur				_____				
			O High blood pressure				_____				_____
			O Inborn heart defects	☐	☐	☐	Malnutrition				
			O Mitral valve prolapse	☐	☐	☐	Migraines				
			O Pacemaker	☐	☐	☐	Night sweats				
			O Rheumatic Heart disease								
☐	☐	☐	Chest pain upon exertion								

Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient/Legal Guardian Date

For completion by dentist

Comments on patient interview concerning health history_____

_____

Significant findings from questionnaire or oral interview _____

_____

Dental management considerations_____

_____

Signature of Dentist Date

3. Why did you choose to come in at this time?

□ General Checkup □ I have areas of pain

□ I have broken fillings or teeth □ I've put it off too long □ Other _____

4. How would you describe the general condition of your teeth?

□ Excellent □ Good □Fair □ Poor

5. If you could change the appearance of your teeth, what would you change?

□ Color □ Crowding or crooked teeth □ Black discolored filling □Other _____

6. Do you believe that having your teeth cleaned regularly will help prevent gum disease, and thereby prevent you from losing your teeth? □ Yes □ No

7. Do you smoke a pack or more of cigarettes a day? □ Yes □ No

8. Do you believe dental disease is avoidable? □ Yes □ No

9. Are you apprehensive about your visit here? □ Yes □ No

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AUTHORIZATION TO PAY BENEFITS

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED,_____
FOR DENTAL BENEFITS. OTHERWISE MADE PAYABLE TO ME FOR DENTAL SERVICES PROVIDED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY THIS AUTHORIZATION.

DATE:_____SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT: _____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act- 45 CFR Parts 160 and 164)

I hereby authorize_____to use and/or disclose the
..[Name of Health Care Provider]
protected health information described below to_____
[Name of Individual]

2. Authorization for Release of Information. Covering the period of health care from

☐_____to _____ **OR** ☐ all past, present and future periods:

a. ☐ I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol and/or drug abuse).

OR

b. I hereby **authorize the release of my complete health record with the exception of the following information:**

☐ Mental health records

☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment

☐ Other (please specify): _____

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

4. This authorization shall be in force and effect until----------at which time this authorization expires.
[Date or Event]

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient

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CONSENT TO DENTAL TREATMENT

I, (Print Name)_____have been informed by Dr. Arvilli, of the need to undergo dental treatment as presented to me on (Date)_____

I have been fully informed about the details of the recommended treatment and alternatives, and agree to accept the terms as recommended by the doctor.

I understand that as the treatment proceeds there r:-.ay be need to change the treatment plan. If this occurs I expect to be informed before any change is instituted.

I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions during or following any treatment, I agree to report them to the office as soon as possible.

I have discussed all of the above with the doctor, and all my questions have been answered.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

Following the explanations, the discussion, and the answers to my questions, I authorize the doctor to complete the treatments described.

_____ _____

Patient Signature If Minor, Signature of a Parent or Guardian

_____ _____

Witness Signature Doctors Signature

_____

Date

BROKEN APPOINTMENT POLICY

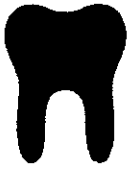
We are commited to the highest quality of care for all of our patients; therefore we schedule all appointments in advance and make every attempt to confirm them. When we schedule your dental visit that time belongs to you and you deserve our undivded attention.

We value our relationship with you and want to be fair, **however, if you are unable to keep an appointment the folowing will apply:**

- **24 hours' notice if you need to cancel or reschedule**
- **$25 fee for broken/missed without prior notification**

Please give the office A PHONE CALL to properly cancel/reschedule your visit within a timely manner.

Please sign here



X DATE

3 D DENTAL ~ Dr. Arvilli

1636 Montauk Hwy, Mastic NY 11950 Suite #3