Myron Goldberg Dentistry

GENERAL FAMILY AND COSMETIC DENTIST

CALL TO SCHEDULE AN APPOINTMENT

(215) 732-0505

PATIENT FORMS

Patients new to Goldberg Dentistry can save time by completing this Health History and the Release and bringing the completed forms with them on their first visit.

PERSONAL HISTORY

Name ______________________________ Date ______________

Home Address ____

City ______________________________ State ________ Zip Code ______________

Date of Birth: ______________________

Telephone: Landline ______________ Work ______________ Cell ______________

Email: ______________________________

How would you like to communicate with the office? Check all that apply:

❑ Email ❑ Text message ❑ Phone call

DENTAL INSURANCE

PRIMARY INSURANCE

Name of Subscriber/Insured ______________________________ Date of Birth ____________

Soc. Sec. # ______________________________

Employer ______________________________

Insurance Company ______________________________

Group # ______________ ID # ______________

SECONDARY INSURANCE

Name of Subscriber/Insured ______________________________ Date of Birth ____________

Soc. Sec. # ______________________________

Insurance Company ______________________________

DENTAL HISTORY

When was your last visit with a dentist? ____________________

When was the last time you had dental x-rays taken? ____________ What type? ____________

Are you happy with the appearance of your teeth? ❑ Yes ❑ No

Are you having any problems with your teeth, gums or facial muscles? ❑ Yes ❑ No

If yes, please describe. ____________________

____

Do you have any complications associated with dental treatment? ❑ Yes ❑ No

If yes, please describe. ____________________

____

MEDICAL HISTORY

From the list below, check any of these which you have had or currently have

❑ AIDS or HIV+
❑ Allergies
❑ Artificial Valve or Joint
❑ Asthma
❑ Bleeding Disorder
❑ Bruise Easily
❑ Chemotherapy
❑ Diabetes
❑ Drug Addiction
❑ Glaucoma
❑ Head/Neck Surgery
❑ Heart Disease
❑ Heart Murmur
❑ Hypertension
❑ IV Bisphosphonate
❑ Liver Disease
❑ Pacemaker
❑ Rheumatic Fever
❑ Sinus Trouble
❑ Stomach Disorder
❑ Venereal Disease
❑ Other: ____________

If female, are you pregnant? ❑ Yes ❑ No Taking birth control? ❑ Yes ❑ No

Note: There are drugs and medications used in some dental care that may decrease the effectiveness of your birth control. Patients taking birth control must utilize an additional method of contraception when using antibiotics.

Do you smoke? ❑ Yes ❑ No If yes, how much per day? ____________

Itemize the **medications** you are taking: ____________________

____

____

Are you allergic to any of the following? Please check all that apply.

❑ Aspirin
❑ Codeine
❑ Darvon
❑ Erythromycin
❑ Keflex
❑ Latex
❑ Local Anesthetic
❑ Penicillin
❑ Percodan
❑ Sulfa
❑ Valium
❑ Other: ____________

Please read the following release and sign below.

It has been explained to me that there are some risks in the administration of local anesthetics. Most risks are related to the position of the nerves, which cannot be determined prior to the administration of the anesthetic agent. Although risks seldom occur, they may include loss of or disturbed sensation in the tongue and lip on the injected site. If this occurs, it is often temporary, and normal sensation usually returns in several days. In very rare cases, the loss of sensation may be prolonged or permanent. Injecting a foreign substance into the body (i.e. an anesthetic) may result in an allergic reaction. These reactions are rare. Unusual reaction to treatment cannot be predicted. If I experience any unanticipated reaction following the injection, I agree to report them to the office as soon as possible.

The success of my dental treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, taking prescribed medication and reporting to the office any change in my health status. I acknowledge that no guarantees or assurances can be given by anyone as to the results that may be obtained.

To the best of my knowledge, the information supplied is correct. The information will be held in strict confidence. I grant the dentist the right to release information obtained from me, as well as treatment information, to third party payers and/or health care practitioners. Please see Privacy Policy..

I authorize the dental staff to perform any necessary dental services, with informed consent. I am responsible for any charges incurred for dental treatment, regardless of dental insurance. I will be responsible for 1.5% interest per month on aging unpaid balances, for any attorney fees incurred to collect these balances and for any bank charges for returned checks.

BROKEN APPOINTMENT POLICY

When you reserve a time with us, please make every attempt to keep your appointment. If you must cancel or change your appointment, please give us 24 hours notice. If you cancel in less than 24 hours, you may be charged a broken appointment fee of $50.

LATENESS POLICY

Please understand we strive to stay on time for your appointment as well as those patients that follow you. In addition, we need enough time to provide you with sensitive and appropriate care. If you are late for an appointment, we reserve the right to reschedule. The broken appointment fee of $50 may apply.

Name____

Signature______________________________________ Date ____________________

If the signature is not that of the patient, what is your relationship? ______________________

Dentist review of history and significant findings:

Signature:______________________________________ Date: ____________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement. *

I, ____ have received a copy of this office's Notice of Privacy Practices.

____
Please print name.

____
Signature

____
Date

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For Office Use Only
==

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign.
- ❑ Communications barriers prohibited obtaining the acknowledgement.
- ❑ An emergency situation prevented us from obtaining acknowledgement.
- ❑ Other (Please specify.)
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