New Patient Information

Mark N. Jacobson, DDS • New York, NY Dentistry

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

Whom may we thank for referring you? _____

ABOUT YOU

Name: _____ I prefer to be called _____ [ ] Male [ ] Female

[ ] Single [ ] Married [ ] Child [ ] Other Birth date: ___/___/___ Age: _____ S.S. #: _____

Home Address: _____ City _____ State ____ Zip _____

Home Phone: (____) _____ Work: (____) _____ ext. ___ Pager: (____) _____

Cell: (____) _____ E-mail Address: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____ City _____ State _____ Zip _____

PERSON RESPONSIBLE FOR ACCOUNT

[ ] Same as above Name: _____ Birth date: ___/___/___ Relation: _____

Billing Address: _____ City _____ State ____ Zip _____

Home Phone: (____) _____ Work: (____) _____ S.S. #: _____

Employer: _____ How long there? _____ Occupation: _____

SPOUSE INFORMATION

[ ] Same as above Name: _____ Birth date: ___/___/___

Employer: _____ Work Phone: (____) _____ ext. _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: _____ Phone: (____) _____ Group/Policy #: _____

Insured's Name: _____ Insured's Birth date: ___/___/___ Relation: _____

Insured's Social Security #: _____ Insured's Employer: _____

Secondary Insurance

Insurance Co. Name: _____ Phone: (____) _____ Group/Policy #: _____

Insured's Name: _____ Insured's Birth date: ___/___/___ Relation: _____

Insured's Social Security #: _____ Insured's Employer: _____

MEDICAL HISTORY INFORMATION

Name of Physician: _____ Phone: (____) _____

Do you have or have ever had any of the following? Please check those that apply:

[ ] Allergies/Hay Fever	[ ] Diabetes	[ ] Heart Surgery*	[ ] Rheumatic Fever
[ ] Anemia	[ ] Epilepsy or Seizures	[ ] Hepatitis	[ ] Rheumatism
[ ] Angina	[ ] Excessive Thirst	[ ] High Blood Pressure	[ ] Sickle Cell Disease
[ ] Arthritis	[ ] Fainting or Dizziness	[ ] HIV*/AIDS	[ ] Sinus Problems
[ ] Artificial Joints*	[ ] Fever Blisters/Cold Sores	[ ] Kidney Problems	[ ] Stroke
[ ] Artificial Heart Valves*	[ ] Frequent Cough	[ ] Liver Problems	[ ] Surgical Shunt*
[ ] Asthma	[ ] Glaucoma	[ ] Mental Disorders	[ ] Thyroid Problems
[ ] Breathing Problems	[ ] Heart Disorder (Congenital)*	[ ] Mitral Valve Prolapse*	[ ] Tuberculosis
[ ] Cancer	[ ] Heart Infection*	[ ] Osteoporosis	[ ] Ulcers
[ ] Chemical Dependency	[ ] Heart Murmur*	[ ] Radiation Treatment	[ ] Venereal Disease
[ ] Chemotherapy	[ ] Heart Pace Maker*	[ ] Respiratory Problems	[ ] Yellow Jaundice

* This condition may require antibiotic premedication for certain dental procedures.

YES NO

[ ] [ ] Do you have any health problems that were not listed above or need further clarifications?
If yes, explain: _____

[ ] [ ] Are you now under the care of a physician?
If yes, explain: _____

[ ] [ ] Have you been admitted to a hospital or needed emergency care during the past two years?
If yes, explain: _____

[ ] [ ] Are you taking any medications or herbals?
If yes, list: _____

[ ] [ ] Are you allergic to any medications or substances?
If yes, please check box below:
[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Iodine [ ] Metal [ ] Latex [ ] Other _____

[ ] [ ] Have you used tobacco?
If yes, explain: _____

WOMEN (Please check): [ ] Pregnant [ ] Trying to get pregnant [ ] Nursing [ ] Taking oral contraceptives

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

X _____ Date _____
Signature of patient, parent or guardian

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it states past and present conditions.

Date:	Exceptions:		Patient's Signature:
_____	_____	[ ] None	X _____
_____	_____	[ ] None	X _____
_____	_____	[ ] None	X _____

Our Financial Philosophy

To create an understanding and partnership in the settlement of your account, No Surprises!
It is important to us that the quality of our business services matches the quality of our dentistry. We want the handling of your account, from the start through final payments to be perceived as an extension of the dental care we provide you and your family.

PATIENT'S ROLE

As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment in a timely manner. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone
In developing a financial arrangement it is important to remember your dental future. Our experience has shown that when an account lingers, patients are likely to defer their appointments. It is discouraging to add new charges to an account when trying to pay off old charges. With this in mind, we will concentrate our efforts on clearing your account in as short a time as is comfortable for both of us.

REGARDING INSURANCE

We may accept assignment of insurance benefits, however the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you. That balance will be due upon billing. We very much appreciate your payment upon receipt of services. In the event that your insurance company denies payment of a service, you are responsible for that fee. Any unpaid balance after insurance pays is due within 45 days.

Please provide permission to process your credit card for any portion not covered by insurance or remaining balance not paid within 45 days after insurance payment is received.

Card Number: _____ Exp. Date: _____ Security Code: _____ Zip Code: _____

Patient Signature: _____ Date: _____

APPOINTMENTS

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, please provide us at least **2 working days advanced notification** so that we may use our time to accommodate other patients. Broken and missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours.

FINANCIAL POLICY

Unless another financial option is PRE-ARRANGED, payment in full is due the day of treatment, or on pre-op visits for sedation appointments. Should a patient have dental insurance with assignment to Dr. Jacobson, the estimated patient portion will be the amount due. Insurance payments without assignment will be sent to the insured with payment due in full.

Payment Options

1. For your convenience we accept Cash, Check, Visa, MasterCard, Amex & Discover.
2. We also offer short and long-term financing options. (Interest-free options may apply)

For Patients with Dental Insurance

Dental insurance plans often pay less than the actual fee for service, therefore the patient or Guarantor is the responsible party for all dental services provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs. Your dental benefits and how they relate to your specific needs will be explained to you during the Treatment Discussion appointment.

Finance Charge and Fees

- Balances in excess of 60 days are subject to a finance charge of 1.5% per month (18% annual).
- Returned checks are subject to a $15 accounting fee.

AUTHORIZATION AND CONSENT

General Consent to Treatment

I agree and consent to a dental examination by Dr. Jacobson.I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Dr. Jacobson to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Dr. Jacobson.

Photography Release

I authorize Dr. Jacobson to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize him to show these photographs to other patients to better explain their treatment options.

I understand and will comply with office **Appointment Policy**.
I understand and will comply with the office **Financial Policy**.
I understand and agree to the **General Consent to Treatment**.
I authorize the **Release of Information**.
I authorize **Photographs** to be taken of me and shown to other patients.

X _____ Date _____
Signature of patient, parent or guardian