Dr. Gary Gurevich, D.D.S

241 West 23rd Street
New York, NY 10011
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8700 25th Ave.
Brooklyn, NY 11214
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WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name _____ (*Last Name* / *First Name* / *Initial*) Soc. Sec.# _____

Address _____

City _____ State_____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

PRIMARY INSURANCE

Person Responsible for Account _____ (*Last Name* / *First Name* / *Initial*)

Relation to Patient _____ Birthdate _____ Soc. Sec.# _____

Address (if *different from patient)* ... Home Phone _____

Cell Phone _____ Email _____

City _____ State_____ Zip_____ _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if *different from patient)* _____ Soc. Sec. # _____

City _____ State _____ Zip_____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

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DENTAL HISTORY

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (X) yes or no if you have had problems with any of the following:

❑ Y ❑ N Bad breath
❑ Y ❑ N Bleeding gums
❑ Y ❑ N Clicking or popping jaw
❑ Y ❑ N Food collection between teeth
❑ Y ❑ N Grinding or clenching teeth
❑ Y ❑ N Loose teeth or broken fillings
❑ Y ❑ N Periodontal treatment
❑ Y ❑ N Sensitivity to cold
❑ Y ❑ N Sensitivity to hot
❑ Y ❑ N Sensitivity to sweets
❑ Y ❑ N Sensitivity when biting
❑ Y ❑ N Sores or growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or previous treatment _____

MEDICAL HISTORY

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ❑Y ❑ N

If yes, describe _____

Are you currently under physician care? ❑ Y ❑ N If yes, describe _____

Have you ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates _____

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Have you ever taken Fen-Phen/Redux? ❑ Y ❑ N

Check (V) yes or no if you have had any of the following:

❑ Y ❑ N AIDS/HIV Positive
❑ Y ❑ N Anaphylaxis
❑ Y ❑ N Anemia
❑ Y ❑ N Arthritis, Rheumatism
❑ Y ❑ N Artificial heart valves
❑ Y ❑ N Artificial joints
❑ Y ❑ N Asthma
❑ Y ❑ N Atopic (allergy prone)
❑ Y ❑ N Back problems
❑ Y ❑ N Blood disease
❑ Y ❑ N Cancer
❑ Y ❑ N Chemical dependency
❑ Y ❑ N Chemotherapy
❑ Y ❑ N Circulatory problems
❑ Y ❑ N Cortisone treatments

❑ Y ❑ N Cough, persistent
❑ Y ❑ N Cough up blood
❑ Y ❑ N Diabetes
❑ Y ❑ N Epilepsy
❑ Y ❑ N Fainting
❑ Y ❑ N Food allergies
❑ Y ❑ N Glaucoma
❑ Y ❑ N Headaches
❑ Y ❑ N Heart murmur
❑ Y ❑ N Heart problems
Describe _____
☐ Y ☐ N Hemophilia/Abnormal Bleeding
☐ Y ☐ N Herpes
☐ Y ☐ N Hepatitis
☐ Y ☐ N High blood pressure

❑ Y ❑ N Jaw pain
❑ Y ❑ N Kidney disease or malfunction
❑ Y ❑ N Liver disease
❑ Y ❑ N Material allergies **(latex,** wool, metal, chemicals)
❑ Y ❑ N Mitral valve prolapse
❑ Y ❑ N Nervous problems
❑ Y ❑ N Pacemaker/ Heart Surgery
❑ Y ❑ N Psychiatric care
❑ Y ❑ N Rapid weight gain or loss
❑ Y ❑ N Radiation treatment
❑ Y ❑ N Respiratory disease
❑ Y ❑ N Rheumatic/Scarlet fever

❑ Y ❑ N Shingles
❑ Y ❑ N Shortness of breath
❑ Y ❑ N Skin rash
❑ Y ❑ N Spina Bifida
❑ Y ❑ N Stroke
❑ Y ❑ N Surgical implant
❑ Y ❑ N Swelling of feet or ankles
❑ Y ❑ N Thyroid disease or malfunction
❑ Y ❑ N Tobacco habit
❑ Y ❑ N Tonsillitis
❑ Y ❑ N Tuberculosis
❑ Y ❑ N Ulcer/Colitis
❑ Y ❑ N Venereal disease

Is patient currently taking any medications? If yes, list all:

_____

_____

Does patient have drug allergies? If yes, list all.

_____

_____

AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ **Date** _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

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Smile Evaluation Checklist

Name:_____ Date:_____

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment and answer the following questions. Please circle your answer.

☐ Do you dislike the color of your teeth? Yes☐ No☐

☐ Do you have spaces between your teeth that bother you? Yes☐ No☐

☐ Do you have chips or uneven edges on your teeth? Yes☐ No☐

☐ Do you feel that your teeth are too long or too short? Yes☐ No☐

☐ Do you have dark fillings that show when you smile? Yes☐ No☐

☐ Do your gums show too much when you smile? Yes☐ No☐

☐ Are your teeth crowded or crooked? Yes☐ No☐

☐ Do you have existing crowns or dental work that you consider "ugly"'? Yes☐ No☐

☐ Are you self-conscious of your teeth and/or smile? Yes☐ No☐

☐ Has anyone (family member, friend, etc.) ever suggested that you should have something done with your teeth or smile? Yes☐ No☐

☐ Do you avoid smiling when you have your picture taken? Yes☐ No☐

☐ Would you like to improve your existing smile? Yes☐ No☐

☐ Do you wish you had a "new smile?" Yes☐ No☐

What concerns do you have regarding dental treatment to improve your smile?

❑ Fear of treatment
❑ Time of treatment concerns
❑ Financial concerns
❑ Distance to office
❑ Not understanding treatment
❑ Embarrassment
❑ Other

_____

_____

_____

ASSIGNMENT OF BENEFITS

Patient Name_____ Date_____

I Hereby irrevocably authorize office of Dr. Gary Gurevich, D.D.S to apply dental insurance benefits (if applicable, No-Fault, Personal Injury Protection and Workers' Compensation) on my behalf and to take all necessary steps to collect such benefits, including but not limited to filing for arbitration as provided by statutes. I hereby authorize payment of any/all dental benefits and insurance proceeds be made on my behalf to the above. I certify that the information I have reported with regard to my insurance carrier(s) is correct. I authorize the release of medical information about me to my dental insurance carrier agents, and any and all other information needed to determine the benefits payable for related service(s).

_____ _____

Signature of Patient/Guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I hereby acknowledge receipt of Dr. Gary Gurevich, D.D.S "Notice of Privacy Practices."

_____ _____

Signature of Patient/Guardian Date

RELEASE OF INFORMATION

I hereby authorize Dr. Gary Gurevich, D.D.S and/or its designees to provide treatment and/or examination and release any information pertinent to my case in the course of my examination or treatment to my physician, insurance company, adjustor, or attorney, if applicable in this case.

_____ _____

Signature of Patient/Guardian Date

CONSENT FOR A MINOR FOR DENTAL TREATMENT

The procedure has been explained in detail and I, as the legal guardian/parent of_____understand it and agree to it. I hereby give my informed consent for_____to be performed.

_____ _____

Signature of Patient/Guardian Date

Financial Policy

If dental insurance information is received at the time of service, as a courtesy, a claim will be submitted to your insurance company. Insurance co-payments and annual deductibles not met for the year are payable when services are rendered. Any services that are not fully reimbursed by your insurance and are indicated on your insurance's explanation of benefits to be the patient's responsibility will be due and payable upon receipt of billing statement. If documentation is not presented at the time of the service, you are responsible for the full amount of charges incurred. Also, please be aware that this office will collect from patient deductibles, patient co-payments, and patient co-insurance payments due.

If you do not have dental insurance, financial arrangements will be made prior to services rendered. Otherwise, full payment will be expected at the time of services.

If your account should become delinquent, and is forwarded to our collection attorney, a 2.5% interest rate will be applied monthly to delinquent balance plus collection cost until the debt is paid in full.

If for any reason you are unable to keep your appointment, 48 hours advance notice must be given to avoid additional fee.

_____ _____

Signature of Patient/Guardian Date

_____

Witness: