ADVANCED DENTISTRY
ROBERT SOROKOLIT D.D.S.

Patient Information

Patient Name: _____ Today's date: _____/_____/_____
Last Name First Name MI

Preferred Name: _____ Birth Date: _____/_____/_____

Social Security #: _____ Age: _____ Sex: ☐ Male ☐ Female

E-mail : _____

Preferred appointment times: ☐ Any time ☐ Morning ☐ Afternoon ☐ Any day M ☐ T ☐ W ☐ T ☐ F ☐

Address: _____
Street Apartment #

_____
City State Zip Code

Patient Health Information

Have you ever had any of the following? Please check those that apply:

- ☐ Attention Deficit Disorder
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Current pregnancy
  Due date: ____/_____
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart attack/stroke
- ☐ Heart surgery/Pacemaker
- ☐ Hepatitis Type: _____
- ☐ High blood pressure
- ☐ HIV / AIDS
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mental disorders
- ☐ Nervous disorders
- ☐ Radiation treatment
- ☐ Respiratory problems
- ☐ Rheumatic fever
- ☐ Smoking # years _____
- ☐ Snoring
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ OTHER
  _____

If none of these apply, please write **"NONE APPLY"** _____

Are you allergic to any of the following?

- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Latex
- ☐ Penicillin / Amoxicillin
- ☐ Sulfa (Bactrim, Septra)
- ☐ Tetracycline
- ☐ Other Drug allergies:
  _____

If none of these apply, please write **"NKDA"** (no known drug allergies)_____

Are you currently taking any medications? ☐ Yes ☐ No
If Yes, please list: _____

Patient Medical History

- Have you been admitted to a hospital or needed emergency care during the past two years? Yes ☐ No ☐
  If yes, please explain: _____
- Are you now under the care of a physician? Yes ☐ No ☐
  If yes, please explain: _____
- Name of physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes ☐ No ☐
  If yes, please explain: _____
- Have you ever taken the drugs phen-phen or Redux? Yes ☐ No ☐
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_____ _____/_____/_____
Signature of patient, parent or guardian Date

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Patient Dental History

- Reason for today's visit: _____
- Date of Last dental visit: _____ / _____
- Previous Dentist Name: _____
- Do you have history of clenching or grinding your teeth? _____
- Have you ever had any complications following dental treatment? ☐Yes ☐ No
  If yes, please explain: _____
- Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know
- How would you rate your smile (worst) 1 -> 10 (best) _____

Phone Numbers

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

(Spouse's work):_____ (Other: _____):_____

Preferred first call number:☐ Home ☐ Work ☐ Cell/other

In case of emergency, who should be notified?

Name: _____ Relationship:_____

Home phone: _____ Cell phone: _____

Pharmacy name: _____ phone: _____

Patient Employment Information

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Dental Insurance Information

PRIMARY INSURANCE

Insurance Plan Name: _____

Insurance Phone Number : _____

Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other_____

Subscriber's name: _____
Last First MI

Subscriber's Birth Date: _____/_____/_____

SSN or ID#:_____Group #:_____

Subscriber's Employer name: _____

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SECONDARY INSURANCE

Secondary Insurance Plan Name: _____

Secondary Insurance Phone Number : _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Subscriber's name: _____
Last First MI

Subscriber's Birth Date: _____/_____/_____

SSN or ID#:_____Group #:_____

Subscriber's Employer name: _____

How did you discover our office?

☐ Referred by: _____

☐ Insurance : _____

☐ Internet: _____
Search engine used

☐ Other : _____

Authorizations

I authorize Advanced Dentistry to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. I herby authorize the release of my dental records to Insurance Carriers or Referred Doctors.

I understand that radiographs and/or photographs may be taken of my teeth and used by the Doctor as examples of procedures performed to be shown to other patients, displayed in the office and/or used for advertisement. I understand that no likeness of my face nor any readily distinguishable features other than a close-up of my teeth will be used by the doctor for any reason without a separate written prior authorization by me.

I have read, understand and agree to the above policies.

Signature: _____ Date: _____/_____/_____

I hereby authorize my insurance company to pay directly to the office of Dr. Robert M. Sorokolit, benefits due to me under the terms of my policy.

Signature: _____ Date: _____/_____/_____

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Billing Policy

First and foremost, we want to express our appreciation to you for selecting our practice. It is our privilege to serve you, and we want your experience with us to be as pleasant as possible as we strive to fulfill your dental needs. The following represents an explanation of our office policies and guidelines concerning financial responsibility.

Please remember your insurance policy is a contract between you and the insurance company, not the doctor. For the convenience of our patients, we will submit all claims of treatment and provide an **estimate** of what your insurance will cover for services from information that we receive over the phone, however we are in no way responsible for payment from any insurance provider. We do not render services on the basis that the insurance company will pay any fees. Remember, necessary treatment should be determined by the doctor and patient together, not dictated by "what the insurance company will pay".

You will be given a treatment plan with expected fees prior to any treatment rendered. Payment is due at time of treatment. A billing statement will be sent to you specifying any insurance payments (if applicable) and your total balance. It is important that you not let your account go past due. In the event your account becomes more than 60 days past due, we will employ outside services to assist in collections and at that time, a 30% finance charge will be added to the total bill. We will make every effort to alert you to the status of your account prior to sending it to collections, and are always willing to find an amicable solution to any problem. We accept cash, major credit cards, personal checks and most debit cards. All returned checks will be charged a $28.00 processing fee.

Signature: _____ Date: _____/_____/_____

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HIPAA CONSENT

Patient Record of Disclosures In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner (check all that apply):

___ Home Telephone_____
- ___ OK to leave a message with details
- ___ Leave message with call-back number only

___ Work Telephone _____
- ___ OK to leave a message with details
- ___ Leave message with call-back number only

___ Cell phone _____
- ___ OK to leave a message with details
- ___ Leave message with call-back number only

___ Text message _____ (if you would like to receive text messages please Indicate your phone carrier_____)
- ___ OK to leave a text with details
- ___ Leave a text with call-back number only

___ Written Communication
- ___ OK to mail to my home address
- ___ OK to mail to my work/office address
- ___ OK to fax to this number _____.

___ I give authorization to leave a message in my absence with _____ (indicate relation to patient) for matters regarding:
- ___ my treatment/test results
- ___ my appointment reminders
- ___ my account such as billing and amount due

I acknowledge that I have read a copy of the Notice of Privacy Practices for HIPAA.

Patient Name (Print) _____

Birthdate: _____

Signature: _____

Date: _____