DR JOHN SIEGAL DDS
49 West 12th Street, #1C,
New York, NY 10011
212-627-2929

Patient Name _____

Social security _____ Date of birth _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Email address _____

Home phone _____ Work phone _____

Cell phone _____ Preferred contact (phone #) _____

Employer _____

Business address _____ City _____ State _____ Zip _____

Do you have dental insurance? Y N

In the event of an emergency is there someone who lives near you that we should contact?

Their name _____

Relation to you _____

Work phone _____ Home phone _____ Cell phone _____

Who referred you to our office? _____

MEDICAL HISTORY

Physician's name _____ Physician's phone _____

Are you currently under the care of physician? Y N

Please explain _____

Are you taking any prescription / over-the-counter drugs?

Please list each one _____

Do you smoke? Y N

Have you ever had any of the following diseases or medical problems?

Heart attack stroke	Y N	HIV+ / Aids	Y N	Hepatitis	Y N
Heart murmur	Y N	Hemophilia/abnormal bleeding	Y N	Fever blisters	Y N
Rheumatic fever	Y N	Shingles	Y N	Severe/frequent headaches	Y N
Mitral valve prolapse	Y N	Kidney problems	Y N	Emphysema/Glaucoma	Y N
Congenital heart defect	Y N	Thyroid condition	Y N	Ulcers/Colitis	Y N
Artificial heart valves	Y N	Cancer/chemotherapy	Y N	Anemia/radiation treatment	Y N
Hi/Low blood pressure	Y N	Psychiatric problems	Y N	Venereal disease	Y N
Blood transfusion	Y N	Asthma/Arthritis	Y N		
Drug/alcohol abuse	Y N	Difficulty breathing	Y N		
Diabetes/Tuberculosis	Y N	Sinus problems	Y N		

Artificial joints *if yes, when?* _____

Are you pregnant? Y N

Pharmacy name, location, and phone # _____

Please list any serious medical conditions/hospitalization: _____

Are you allergic to any of the following drugs?

Penicillin	Y N	Tetracycline	Y N	Latex	Y N
Aspirin	Y N	Dental Anesthetics	Y N	Other	Y N

DENTAL HISTORY *New patients only*

Why have you come to the dentist today? _____

_____

Are you currently in pain? Y N

Have you had a serious/difficult problem with any previous dental work? Y N

If yes please explain: _____

_____

Have you ever had dental implants placed? Y N

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Y N

If yes please explain: _____

_____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? Y N Do your gums ever bleed? Y N

How many times a week do you floss? _____ How many times a day do you brush? _____

Type of bristles? ☐ Hard ☐ Medium ☐ Soft

When was your last dental cleaning? _____

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at this time, please ask us. We are happy to help. ***Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.***

I understand and authorize the office of John Siegal, DDS to take all diagnostic materials needed to make a final diagnosis of dental treatment. Diagnostic materials may include intra-oral pictures, radiographs, digital radiographs, diagnostic models, photographs and slides.

I authorize John Siegal, DDS to perform and or administer any and all forms of treatment, medication and anesthesia that may be necessary. I understand that the dental treatment presented to me is my financial responsibility and that all fees for services are due and payable up front and/or at the completion of treatment as authorized by John Siegal, DDS and or administrator.

I will assume responsibility of notifying John Siegal, DDS of any changes in my medical history or contact information.

I understand that the office of John Siegal, DDS reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

We reserve the right to charge our patients a fee for appointments that are broken or not cancelled within 24 hours notice.

Patient's Signature: _____ ***Date:*** _____

OFFICE USE ONLY

I have verbally reviewed the medical with the patient named herein. Initials _____ *Date* _____

Comments _____ Date _____
Comments _____ Date _____
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OFFICE POLICY

Payment is expected at the time services are provided unless prior financial arrangements have been made. There is a $95 cancellation fee for all appointments not cancelled at least 24 hours in advance.

I have read and understand the office policies of John W. Siegal, DDS as stated above.

Print name _____ Signature _____

Date _____

DR JOHN SIEGAL DDS

PATIENT HIPAA AWARENESS

With my permission, Dr. John Siegal may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. John Siegal's notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. John Siegal reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Dr. John Siegal may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice on carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including results among other things.

With my permission, the office of Dr. John Siegal may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. John Siegal restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Dr. John Siegal to use and disclose my PHI for TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Print name _____ Signature _____

Print name if legal guardian _____ Signature of legal guardian _____

Date _____