GLASTEIN PALACIO
DENTAL GROUP

99 Fieldstone Ave
Harstale NY 10530
(914) 761-1500

Patient Information:

Name:		
Address:	City:	Zip Code:
Birthday:	Social Security #:	
Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Employer:	Occupation:	
Work Phone:	Home Phone:	
Cell Phone:	Email Address:	

If Patient is NOT the primary holder, please complete the following:

Name of person responsible for this account:		
Relationship to patient:		
Address:	City:	Zip Code:
Cell phone:	Birthday:	Social Security #:
Employer	Occupation:	
Email Adress:		

General Information:

Whom may we thank for referring you:	
General physician:	City:
Emergency Contact:	Phone:

Dental Insurance Information:

Primary Insurance Company	Secondary Insurance Company
Company Name:	Company Name:
Policy Holder:	Policy Holder:
Date of Birth:	Date of Birth:
Patient's relationship to policy Holder:	Patient's relationship to policy Holder:
Social Security # or ID #:	Social Security # or ID #:

Medical & Dental History Questionnaire

Patient Name:	Date:
Current Medications and Supplements:	
Preferred Pharmacy:	
Allergies & Symptoms:	

Although some of the following questions may be unrelated to your teeth, they are associated with proper management of your oral health. Do you have or have you had any of the following:

	Yes	No		Yes	No
Heart Problems (if yes, describe)	☐	☐	Epilepsy or other neurological disorder	☐	☐
High Blood Pressure	☐	☐	History of Head Trauma	☐	☐
Low Blood Pressure	☐	☐	Frequent or Severe Headaches or Migraines	☐	☐
Pacemaker	☐	☐	Thyroid Concerns	☐	☐
Artificial Heart valve	☐	☐	Diabetes, Type: HbA1c:	☐	☐
Joint Replacement (if yes, describe) Date: Body Part:	☐	☐	Family history of Diabetes	☐	☐
Is antibiotic premed required before treatment? Underlying condition: Since when:	☐	☐	HIV+ or Acquired Immune Deficiency Syndrome	☐	☐
	☐	☐	Oral Herpes or Cold Sores	☐	☐
Easy Bruising	☐	☐	Dry Mouth	☐	☐
Abnormal Bleeding	☐	☐	Have you ever received an organ transplant?	☐	☐
Frequent Nose Bleeds	☐	☐	Have you donated an organ transplant?	☐	☐
Anemia	☐	☐	Have you ever had cancer? If yes, type?	☐	☐
History of Blood Transfusion	☐	☐	If yes, medication/treatment?	☐	☐
History of Stroke or TIA	☐	☐	Have you taken Fosamax/Boniva/Actonel/ Zometa? **OR** IV bisphosphonates, when?	☐	☐
Sinusitis	☐	☐	Depression or Anxiety	☐	☐
Asthma	☐	☐	History of Alcohol Abuse	☐	☐
Tuberculosis	☐	☐	History of Drug Abuse	☐	☐
COPD	☐	☐	Do you smoke?	☐	☐
Hepatitis, Type:	☐	☐	If yes, how often?	☐	☐
Liver Problems	☐	☐	Do you use smokeless tobacco?	☐	☐
Kidney Problems	☐	☐	If yes, how often?	☐	☐
Bladder Problems	☐	☐	**Women**	☐	☐
Ulcers	☐	☐	Pregnant? Due Date:	☐	☐
Gallstones or Gallbladder Problems	☐	☐	Are you nursing?	☐	☐
Arthritis	☐	☐	Contraceptives or Other Hormones	☐	☐
Back or Neck Pain	☐	☐		☐	☐
Osteoporosis	☐	☐	**Men**	☐	☐
Osteopenia	☐	☐	Do you have history of Prostate Cancer?	☐	☐
History of Fainting	☐	☐		☐	☐
History of Seizures	☐	☐		☐	☐

Dental History:
Reason for today's visit:
Date of last dental care:
Former dentist and phone #
Have you ever had any serious trouble associated with a previous dental experience:
Please list any other comments regarding your teeth, mouth or dental history:

Patient Signature: _____ Date:_____

Patient Authorizations

☐	I authorize the release of my dental records from Glastein Palacio Dental Group and/or individuals involved in my dental care. I further authorize the release of records from any individuals to Glastein Palacio Dental Group.
☐	I authorize insurance payments to be made directly to Glastein Palacio Dental Group. I understand I am responsible for unpaid balance.
☐	I am aware that if I don't provide adequate notice to a change in an appointment date/time, I may be charged a fee. 7 calendar days for a surgical appointment ($200) and 2 business days for a cleaning appointment ($25).
☐	I am aware of and have received notice of Health Insurance Portability and Accountability Act (HIPPA).

Notice of Privacy Practice- Acknowledgment

We keep a record of the health care services we provide for you. You may ask to see and copy that record. We will **not** disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting us.

Our **Notice of Privacy Practices** describes in more detail how your health information may be disclosed and you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Authorization to Discuss Treatment & Financial Information

By my signature below, I authorize Glastein Palacio Dental Group and staff to discuss treatment and financial information with the people named below for the duration of my treatment with the office.

Name:	Relation to Patient:	Cell Phone:

☐ I do not authorize Glastein Palacio Dental Group to discuss treatment and financial information with anyone other than myself.

Patient Signature:	Date:

GLASTEIN PALACIO
DENTAL GROUP

Email and Text Messages Program Consent Form

W are happy to provide the option to participate in our online patient communication system. Some of the features include the ability to:

1. Receive or confirm appointments via email.
2. Receive text message appointment reminders.
3. Receive text reminders to schedule upcoming/pending treatments.
4. Submit patient satisfaction reviews

You may choose to discontinue your participation in our online communication system at any time by simply clicking the “unsubscribe” link found at the bottom of each email, or by replying “STOP” to a text message from us. Standard text messaging rates may apply.

Please provide us with the following contact information:

Cell phone: _____

Email: _____

We use this information strictly for the purposes of communication with you more efficiently. Our goal is to provide you with excellent treatment as well as overall service and satisfaction. We may disclose patient health information (PHI) to third parties that perform services for this practice in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Our affiliates do not sell, share or rent personal identifiable information unless required by law. We do not send any email or other forms of communication without your permission.

Please sign below to indicate that you agree to allow us to use this information in order to provide our services.

Signature: _____ Date:_____