CENTRAL PARK
DENTAL AESTHETICS

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Gender: _____

Home Phone: _____ Work: _____ Cell: _____

Email Address: _____

Address: _____

_____

Date of Last Dental Visit: _____ Reason for Visit: _____

Please Check the Following that Apply:

- ☐ Anxiety
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Epilepsy
- ☐ Ecessive Bleeding
- ☐ GERD/Acid Reflux
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV+
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Migranes
- ☐ Morning Headaches
- ☐ Nervous Disorder
- ☐ Obstructive Sleep Apnea
- ☐ Pacemaker
- ☐ Pregnancy/Due Date:
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Snoring
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Other

☐ Allergies: _____

Have you ever had any complications following dental treatment?: _____

Have you been hospitalized during the past two years?: _____

Are you now under the care of a physician?: _____

Name and Number of Physician: _____

Are you taking any medication?: _____

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

Patient/Guardian Signature: _____ Date: _____

Whom may we thank for referring you to our practice: _____

200 West 57th Street, Suite 303
New York NY 10019
212 601 2666
info@cpdanyc.com

Breathing and Wellness

Section 1: Epworth Sleepiness Scale

Please indicate how likely you are to doze off or fall asleep in the following situations:
0 = Never, 1 = Slight, 2 = Moderate, 3 = High Chance of Dozing

Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting in a public place	0	1	2	3
As a passenger in a car for one hour	0	1	2	3
Driving a car stopped for a few minutes in traffic	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting down quietly after lunch without alcohol	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3

Total Score:

Section 2: Patient Evaluation

Fill in the blanks, circle yes/no for each response

BMI (See Attached Chart) _____

Neck Circumference (cm) _____

Have you gained at least 15lbs or more in the past 6 months? Yes / No

Section 3: Subjective Sleep Evaluation

Please circle yes/no for each question

Do you snore?	Yes / No
You, or your spouse, would consider your snoring louder than a person talking?	Yes / No
Your snoring occurs almost every night?	Yes / No
Your snoring is bothersome to your bed partner?	Yes / No
Do you feel that in some way your sleep is not refreshing or restful?	Yes / No
Do you wake up at night or in the morning with headaches?	Yes / No
Do you experience fatigue during the day and have difficulty staying awake?	Yes / No
Do you have blocked nasal passages?	Yes / No
Do you have trouble remembering things or paying attention during the day?	Yes / No
Do you have high blood pressure?	Yes / No
Has anyone observed you stop breathing during your sleep?	Yes / No
Do you ever wake up choking or gasping?	Yes / No
Do you grind your teeth while sleeping?	Yes / No

Section 4: Prior Diagnosis

Have you previously been diagnosed with sleep apnea? Yes / No

When were you diagnosed? _____

Were you put on a CPAP or a sleep appliance? If so, which one: _____

Are you still using your CPAP or sleep appliance every night? _____

When was your last sleep test? _____

Notes: Please insert any notes for the doctor regarding snoring, sleep patterns or sleep apnea that you feel may be appropriate

_____

_____

_____

Patient Signature: _____ Date: _____

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Emergency Contact

Name: _____ Address: _____

Phone #: _____ Relationship to patient: _____

Consent for Service

I hereby authorize Central Park Dental Aesthetics to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my needs. I hereby irrevocably grant Central Park Dental Aesthetics permission to: use, publish, copyright, and/or reproduce in any form all photographs, videos or statements made of me this day and throughout the course of treatment, without further compensation to me. All images shall be considered the property of Central Park Dental Aesthetics solely and completely. I agree that any disputes arising from the agreement will be settled under applicable New York State law.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask complete recital of any possible complications.

I give consent to the doctor's or staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, payment and health care operations.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for any co-payment of all dental services not convered by the insurance. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render service on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at request, by the doctor, I agree to pay therefore the reasonable value of said services to said doctor, or their assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditins of treatment and payment and agree to their content.

Patient/Guardian Signature: _____ Date: _____

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HIPAA Consent

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my health information. I understand that this information can and will be used to: (1)Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly. (2) Obtain payment from third-party players. (3) Conduct normal healthcare operations such as quality assessment and physician certifications.

I have been informed by you about your "Notice of Privacy Practices," containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such "Notice of Privacy Practices" prior to signing this consent. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization of any time to obtain a current copy.

I understand that I may request in writing that you restict my private information. Also that it is used or disclosed to carry out treatment, payment, or healthcare options. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____

Party Responsible for Payment

If self, please ONLY print your name

Name: _____ Date: _____

Social Security #: _____ Gender: _____

Home Phone: _____ Work: _____ Cell: _____

Email Address: _____

Address: _____

_____

Credit Card Authorization Information

Name: _____

Name on Card: _____

Card Type: Visa MasterCard Discover Amex

Card Number: _____ Exp. Date: _____

Security Code: _____

Signature: _____ Date: _____

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Payment Procedures for 30 Days After Treatment / Receipt of Insurance Benefit Payment

I have been made fully aware that this is only an estimate and my insurnace company may pay more or less than the estimated amount. I am paying the estimated co-payment with the understanding that I am still responsible for whatever balance remains after the insurance payment is received. If the actual insurance payment is more than the estimated amount, I will receive a refund of the difference. If the actual insurnace payment is less than the estimated amount, I will be notified by email of the remaining balance due. I agree to pay that remaining balance in full within 30 days. If for any reason I cannot make scheduled payments, the patient must immediatly contact Central Park Dental Aesthetics to make acceptable arrangements. Central Park Dental Aesthetics reserves the right to refer all unpaid accounts to collection agencies. Any fees associated with collection, including collection agency contingency fees, attorney's fees, and/or court costs, will be added to the patient's account balance, in addition to an 18% interest fee. After accounts are places within collection agencies, all patient visits and procedures will be on a cash only basis.

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for services and materials not paid by my dental or health benefit plan. To the extent permitted by law, I consent to your use and disclosure of my personal health information to be used for the sole purpose of collecting any amounts due to the practice.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____

Patient Attendance Policy Agreement

Through the years, our office has strived to provide each patient with the highest quality of care while attempting to accommodate your schedule and ours. In order to do this, we provide reserved times for each patient in order to minimize waiting times and assure quality treatment.

Cancellations, especially last minute ones, along with patient no-shows, decrease our ability to accomodate the scheduling needs of our other patients. We ask for your full cooperation with our policy as follows:

(1) If you are unable to keep a scheduled appointment, please notify us 24 hours or more in advance. For whitening and specialist appointments, 48 hours notice is required. Cancellations fees will be applied to all missed specialist and whitening appointments, no exceptions.
(2) All cancellations that occur within 24 hours and no-shows will be documented in our records, with a $100.00 charge for hygiene appointments, a $150.00 for doctors appointments.
(3) All cancellations that occur within 48 hours and no-shows will be documented in our records, with a $250.00 charge for a specialist appointment or whitening appointment.
(4) If you accumulate 3 cancellations or no-shows, we will be unable to provide you with services at our office.

We believe this policy is necessary for the benefit of all our patients, and allows us to provide the highest quality of treatment for everyone.

Thank you for your cooperation.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____

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