JEFFREY C. SKLARIN, DDS & SEYMOUR KOSLOWSKY, DDS
Patient information

Name_____Date_____
Last First MI
Address_____City_____State_____Zip_____

Telephone numbers: home_____cell_____work_____email_____

Date of Birth____/____/_____ Age____Social Sec.No._____-_____-_____ Sex: M F
Marital status_____ Emergency contact_____relationship_____phone_____
Occupation_____Employer name and address_____
REFFERRED TO THIS OFFICE BY_____
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*REASON FOR THIS VISIT_____
Date of last dental exam_____date of last set of complete dental xrays_____
Please list any dental concerns you may have at this time:_____

MEDICAL HISTORY Are you in good health? Yes No
Any major changes in your general health the past 5 years? Yes No -If yes, please explain_____
_____
List all hospitalization and serious illnesses including dates_____
_____
Do you have or ever had any of the following: please circle

Heart Murmur/Mitral Valve Prolapse Heart Attack/Angina Irregular Heartbeat/Pacemaker
High Blood Pressure Rhematic Fever/Heart Disease Prosthetic or Artificial Heart Valve
Autoimmune Disease/Lupus Kidney Disease Liver Disease/Hepatitis Tuberculosis
Psychiatric problems Diabetes Asthma/Emphysema/Breathing problems
Thyroid problems HIV/AIDS Stroke Seizures/Convulsions Cancer/Radiation
Ulcers Blood or Bleeding Disorders Venereal Disease
--please explain any circled answers_____
_____
Have you ever needed to take antibiotics prior to dental treatment? Yes No -if yes, why?_____
Do you have any allergies to any medications? Yes No -if yes, what?_____
Do you have an allergy to latex? Yes No
List all medications you are currently taking including reason why and dosage_____
_____
Physicianôs name,address, and phone number_____
Women only: Are you pregnant? Yes No -if yes, how many months pregnant?_____

INSURANCE INFORMATION:
Dental Insurance Plan/Company_____ id# of insured_____
Group #_____Insurance plan address_____
Name of insured_____relationship to patient_____
Soc.Sec.No. of insured_____ date of birth of insured_____
Tel. No. of insured: home_____cell_____work_____
Employer of Insured and address_____
---Secondary insurance (if exists, please list all pertinent info.)_____

FINANCIAL AGREEMENT

-all dental services performed without previous financial arrangements must be paid for at the time services are performed.
-patients with dental insurance understand that any procedures or portions of any procedures not paid by the insurance company becomes the patientôs responsibility and shall be paid for promptly.
-if a patient has a dispute regarding insurance payment, they should contact the insurance company directly to resolve the dispute.
-appointments cancelled less than 24 hours prior to the appointment are subject to a cancellation fee.

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

X_____ date_____
Signature of patient,parent or guardian

NOTICE OF PRIVACY PRACTICES
(HIPAA)

The privacy practices are listed on the form below. I have read these privacy practices and I am aware that I can obtain a copy of these privacy practices at any time.

_____
print name

_____
signature

_____
date