



Name _____ Date Of Birth _____ Age: _____

Address _____ City _____

ZipCode _____ Phone _____ CellPhone _____

Email _____

Soc. Sec. # _____ Marital Status: _____

Emergency Contact Name _____ Phone# _____ Relation: _____

Patient Employed By: _____ BusinessPhone _____ Occupation: _____

Name of General Dentist _____

Name of Physician _____

Name of Pharmacy _____ City _____

Insurance Information

Primary Insurance Info:

Insurance Company _____ ID# _____

Group# _____ Subscriber Name _____

Subscriber DOB: _____ Subscriber Relation _____

Insurance Co. Address _____ City _____

Zip Code: _____ Phone _____

Employer _____

Secondary Insurance Info:

Insurance Company _____ ID# _____

Group# _____ Subscriber Name _____

Subscriber DOB: _____ Subscriber Relation _____

Insurance Co. Address _____ City _____

Zip Code _____ Phone _____

Signature _____ Date _____



Name: _____

Health History

	Yes	No
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>
Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking any drug or medicine? ...(If yes please list below).....	<input type="checkbox"/>	<input type="checkbox"/>

Have you had excessive bleeding requiring special treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any known drug reaction?	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to or have you reacted adversely to:		
Local Anesthetics (Novocain)?	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other Antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, Sedatives, Sleeping Pills?	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin?	<input type="checkbox"/>	<input type="checkbox"/>
Other Drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any of the following conditions?		
Rheumatic Fever?	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease?	<input type="checkbox"/>	<input type="checkbox"/>
Stroke?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
High or Low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Liver or Kidney Disorders (Hepatitis)?	<input type="checkbox"/>	<input type="checkbox"/>
Aids or HIV?	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Disorders (Tuberculosis)?	<input type="checkbox"/>	<input type="checkbox"/>
Anemia?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any other serious illnesses or operations?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family ever had Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had psychiatric therapy?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had periodontal treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had "trench mouth"?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had orthodontic therapy?	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Women: Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>

So that we may maintain the operation of our office on sound principles and to assure you and other patients of uninterrupted treatment it is necessary for all patients to accept and adhere to a definite arrangement of appointments and fees. Once you have made an appointment, remember this time is reserved for you – therefore, AT LEAST 24 HOURS NOTICE MUST BE GIVEN IF CANCELLATION IS ABSOLUTELY NECESSARY, OTHERWISE USUAL FEE CHARGE WILL BE MADE.

Signature _____ Date _____



Patient Communication Consent Form

I agree to allow the staff at Hudson Valley Periodontics to contact me using the following methods regarding my personal health information, evaluation and treatment. I authorize / do not authorize Dr. Tucker, Dr. Csillag and their staff to leave messages for me when I am unavailable as indicated below.

Check to confirm Approval of Method	Method	Number / Address	Leave Messages	
	Home Phone		YES	NO
	Cell Phone		YES	NO
	Work Phone		YES	NO
	Email		YES	NO

I authorize Dr. Tucker, Dr. Csillag and his staff to discuss my personal health information with my general dentist and the individuals listed below. I understand that by leaving spaces blank, I am indicating my choice that I do not want my information shared with or released to anyone else.

Name	Relationship to Patient	Phone Number

By my signature below, I hereby acknowledge that I have read and understand the information provided on this Consent form. I understand the risks associated with different methods of communication, especially email, and consent to the communications outlined in this consent form.

Patient Name Printed

Date

Signature _____ Date _____

HUDSON VALLEY PERIODONTICS AND IMPLANTOLOGY

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgment

I, _____ have received a copy of the office's Notice of Privacy Practices.

First _____ Last _____

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgment

___ An emergency situation prevented us from obtaining acknowledgment

___ Other (Please Specify)

