HUDSON VALLEY
PERIODONTICS & IMPLANTOLOGY

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_____

HUDSON VALLEY
PERIODONTICS & IMPLANTOLOGY

Name:_____

Health History

	Yes	No
Are you in good health?		
Are you now under the care of a physician?		
Are you taking any drug or medicine? …(If yes please list below)……		

_____ _____ _____ _____

_____ _____ _____ _____

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

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,

Signature_____Date_____

HUDSON VALLEY
PERIODONTICS & IMPLANTOLOGY

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.

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.

Signature_____Date_____

HUDSON VALLEY
PERIODONTICS & IMPLANTOLOGY

_____ _____

Patient Name Printed **Date**

Signature_____Date_____