Spyridon J. Condos, DDS LLC

Thank you for choosing our office. We will strive to provide you with the best possible dental care.
To help us meet your entire dental healthcare needs, please fill out this form completely.

PATIENT INFORMATION

Patient's Last Name	First	Middle		Preferred Name / Nickname
Birthdate / /	Social Security Number	❑ Male ❑ Female	❑ Mr. ❑ Ms. ❑ Dr. ❑ Mrs.	❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced
Street Address				Home Phone ( )
City		State	Zip	Cell Phone ( )
Email Address	Occupation	Employer		Work Phone ( )

How did you hear about our office? ❑ Family ❑ Friend/ Coworker ❑ Insurance Directory ❑ Internet/ Email ❑ Flyer/ Direct Mailing ❑ Outdoor Signs ❑ Marketing Representative

Whom may we thank for referring you to your practice?	Other Family Members Seen Here

INSURANCE (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill			Relationship to Patient (self/spouse/child)
Card Type (circle one): Amex / Visa / Master Card / Discover / CareCredit / Lending Club /Other Card Number:			Card Expiration Date:
Subscriber's Name:	Subscriber's Social Security #:	Subscriber's Email Address:	Subscriber's DOB: / /
Subscriber's Street Address (if different from patient's)			Subscriber's Cell Phone ( )
City		State / Zip	Subscriber's Work Phone ( )
Primary Insurance Company		Subscriber's ID #:	Group #:
Secondary Insurance Company		Subscriber's ID #:	Group #:

DENTAL HISTORY

Reason for Today's Visit ❑ Routine Exam/Cleaning ❑ Pain/Emergency ❑ Consultation ❑ Other_____

Are you in pain? ❑ Yes ❑ No If yes, how long?_____

Please indicate any of the following problems:

- ❑ Red, swollen or bleeding gums
- ❑ Sensitive teeth or gums
- ❑ Sensitive to heat
- ❑ Sensitive to cold
- ❑ Broken/chipped tooth
- ❑ Lost/broken filling(s)
- ❑ Teeth grinding
- ❑ Ringing in ear
- ❑ Bad breath
- ❑ Stained teeth
- ❑ Blisters/sores in or around the mouth
- ❑ Discomfort, clicking or popping in jaw

Do you require pre-medication (antibiotics prior to dental treatment)? ❑ Yes ❑ No ❑ Don't Know

Previous Dentist	City, State	Phone
Last Dental Visit	Last X-Rays	

Reasons for changing dentist: ❑ Moved ❑ Changed insurance ❑ Not satisfied with previous dentist ❑ Referred to our office ❑ Other_____

MEDICAL HISTORY

Name of Primary Physician	Physician's Phone ( )

Please indicate if you have or ever had any of the following diseases or medical conditions:

❑ Heart Attack / Stroke	❑ Stomach Problems / Ulcers	❑ Severe/Frequent Headaches
❑ Heart Surgery / Pacemaker	❑ Psychiatric Problems	❑ Frequent Neck Pain
❑ Heart Murmur	❑ Venereal Disease	❑ Shingles
❑ Rheumatic Fever	❑ Alcohol / Drug Abuse	❑ Asthma
❑ Mitral Valve Prolapse	❑ Tuberculosis (TB)	❑ Difficulty Breathing
❑ Artificial Valves	❑ Jaw Problems (TMJ / TMD)	❑ Diabetes
❑ Heart Disease	❑ Cancer / Tumor	❑ Anemia
❑ Congenital Heart Defect	❑ Chemotherapy / Radiation	❑ Low Blood Pressure
❑ Chest Pains	❑ Hepatitis	❑ High Blood Pressure
❑ Scarlet Fever	❑ HIV+ / AIDS	❑ Bleeding Problems
❑ Kidney Problems	❑ Arthritis / Rheumatism	❑ Glaucoma
❑ Liver Problems	❑ Artificial Bones / Joints	❑ Back Problems
❑ Respiratory Problems	❑ Emphysema	❑ Other Medical Conditions_____
❑ Sinus Problems	❑ Fainting / Seizures / Epilepsy	

Please list all medications you are currently taking:

Are you allergic to any of the following?

❑ Aspirin	❑ Penicillin	❑ Local Anesthetics
❑ Ibuprofen	❑ Codeine	❑ Other Medications_____
❑ Sulfa Drugs	❑ Latex	

Do you use tobacco?	❑ Yes	❑ No	If yes, what form?_____	How much?_____	How long?_____

For Women: Are you pregnant? ❑ Yes ❑ No If yes, how long?_____ Are you nursing? ❑ Yes ❑ No

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)		Relationship to Patient
Home Phone ( )	Cell Phone ( )	Work Phone ( )

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our Office Administrator, Carrell Clarke. We accept Cash, Checks, Master card, Visa card, American express card, and Discover card. We also offer financing through Carecredit and Lending Club.
- I authorize and give consent to perform any necessary or advisable services during diagnosis and treatment.
- I authorize consent for provider and staff to communicate with all physicians, hospitals, laboratories and insurance claims department pertaining to diagnosis and treatment on my behalf. I understand that I have the right to deny consent of release of my information at anytime.
- We are "Out of Network" with all dental plans. If your dental insurance company allows for "Out of Network" coverage, we will file all dental claims and you will be responsible for paying the portion not covered by your dental insurance carrier. You are solely responsible for the full payment of all services not covered by your insurer and payment will be due at the time services are rendered. For all dental plans where "Assignments of Benefits" are issued to the subscribers we will expect payment of the full reimbursement amount plus your portion if any, no later than 48 hours after receipt. According to NYS Law we cannot write off any balances for services that were already paid for by your insurance carrier.
- We must emphasize that, as dental care providers, our relationship is with you, not your insurance company therefore you are responsible for all charges from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Spyridon J. Condos, DDS, LLC. I understand that I am financially responsible for any balance.

X _____

PATIENT/GUARDIAN SIGNATURE DATE