Michael Schiffman, D.M.D.

Patient Information

Name:_____ Date of Birth:_____

Address:_____City:_____

State:_____ Zip code:_____ Driver's Lic.#_____Sex: Male_____ Female_____

Social Security #:_____Occupation:_____Marital Status_____

Home Phone: _____Work Phone:_____ext._____

Cell Phone:_____ Email address:_____

Check if you **DO NOT** want to receive **confirmations** by: email_____ text messages _____

Emergency Contact:_____ Relationship:_____

Contact Phone number:_____ Referred by:_____

Insurance

Subscriber Name:_____ Date of Birth:_____

Subscriber I.D. # or Social Security #:_____Driver's Lic. #_____

Insurance Company:_____

Group Name: _____Group #:_____

Name of Employer:_____

Employer Address: _____Phone number:_____

Name & Address of Responsible Billing Party: _____

_____Phone Number:_____

I understand my dental insurance is a contract between myself and the carrier. I understand I am responsible for the full amount of dental fees incurred. Any payments received by Dr. Schiffman from the insurance company will be credited to my account. I understand that I am responsible for the balance of the treatment not covered by insurance. If there is a credit on my account, I understand Dr. Schiffman will refund it to me.

Patient/Guardian Signature:_____Date:_____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*** Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
*** Obtain payment from third-party payers.**
*** Conduct normal healthcare operations such as quality assessments and physician certifications.**

I acknowledge that I received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature of Patient, Parent, or Guardian_____Date_____

Michael Schiffman, D.M.D.
Medical History

Patient Name:_____Date of Birth:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you are taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name of physician(s)_____Phone #

Are you under a physician's care at the present time?..... ☐ Yes ☐ No
If yes, explain:

Have you ever been hospitalized or had a major operation?..... ☐ Yes ☐ No
If yes, explain:

Are you taking any medications, pills, or drugs?..... ☐ Yes ☐ No
If yes, please list:

_____

_____

Do you take or have you taken Phen-fen or Redux?..... ☐ Yes ☐ No

Are you on a special diet?..... ☐ Yes ☐ No

Do you use tobacco?..... ☐ Yes ☐ No

Do you use controlled substances?..... ☐ Yes ☐ No

Women: Are you pregnant or trying to get pregnant?..... ☐ Yes ☐ No

Are you nursing?..... ☐ Yes ☐ No

Are you taking oral contraceptives?..... ☐ Yes ☐ No

Are you allergic to any of the following:

☐ Aspirin	☐ Penicillin	☐ Codeine
☐ Local Anesthetics	☐ Acrylic	☐ Metal
☐ Latex	☐ Other	

_____

_____

Medical History

Do you have, or have had, any of the following?

☐ Aids/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Renal Disease
☐ Alzheimer's disease	☐ Diabetes	☐ Hepatitis A	☐ Rheumatic Fever
☐ Anaphylaxis	☐ Drug Addiction	☐ Hepatitis B or C	☐ Rheumatism
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Scarlet Fever
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Shingles
☐ Arthritis/Gout	☐ Epilepsy or Seizures	☐ Hives or Rash	☐ Sickle Cell Anemia
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Sinus Trouble
☐ Artificial Joint	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Spina Bifida
☐ Asthma	☐ Fainting/Dizziness	☐ Kidney Problems	☐ Stomach problems
☐ Blood Disease	☐ Frequent Cough	☐ Leukemia	☐ Stroke
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Liver Disease	☐ Swelling of Limbs
☐ Breathing Problems	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Bruise Easily	☐ Genital Herpes	☐ Lung Disease	☐ Tonsillitis
☐ Cancer	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Chemotherapy	☐ Hay Fever	☐ Pain in Jaw Joints	☐ Tumors or Growths
☐ Chest Pain	☐ Heart Attack/Failure	☐ Parathyroid Disease	☐ Ulcers
☐ Cold Sores	☐ Heart Murmur	☐ Psychiatric Care	☐ Venereal Disease
☐ Congenital heart Dis-order	☐ Heart Pace Maker	☐ Radiation Treatments	☐ Yellow Jaundice
☐ Convulsions	☐ Heart Trouble/Disease	☐ Recent Weight Loss	

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain below:___

_____

Comments:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:_____Date_____

Michael Schiffman, D.M.D.

Dental History

When was your last visit to the dentist? _____Months _____Years

Reason for leaving last dentist?_____

When was your last dental cleaning? _____Months _____Years

How often do you brush your teeth?_____

How often do you floss? _____everyday _____couple times per week

_____A couple times per month _____Rarely

Does it tear when you floss? □ Yes □ No

Do you have any broken teeth? □ Yes □ No

Do you use any tobacco products? □ Yes □ No

Have you ever had braces? □ Yes □ No If yes, when?_____

Have you ever had your wisdom teeth out? □ Yes □ No If yes, when?_____

Do your gums bleed when you brush or floss? □ Yes □ No

Do you get food packed in between your teeth? □ Yes □ No

Do you grind your teeth? □ Yes □ No

Do you snore? □ Yes □ No

Do you have sensitive teeth? □ Yes □ No

Do you have any discomfort? □ Yes □ No

Would you like fresher breath? □ Yes □ No

If you could change your smile, what would you like to do? _____

_____

_____

Do you have any concerns not mentioned? _____

_____

_____

Michael Schiffman, D.M.D.

1245 S. Cedar Crest Blvd., Suite 204
Allentown, PA 18103
(610)432-2841 fax (610)432-7820

Request for X-ray & Dental Records Transfer

Patient name: _____Date:_____

Please transfer my x-rays and any other necessary records to:

Dr. Michael Schiffman
1245 S. Cedar Crest Blvd., Suite 204
Allentown, PA 18103-2841

(The following is to be completed by previous dental office)

Last seen in your office_____ Last bitewings taken_____

Last FMX, date taken_____ ____Premedication_____

Last cleaning & exam_____ Recall frequency_____

Treatment recommendations:_____

_____

Other:_____

I authorize the release of this information & my most recent records to Dr. Michael Schiffman.

_____ _____

Patient Signature Date

MICHAEL SCHIFFMAN, D.M.D.
1245 S. Cedar Crest Blvd., Ste. 204
Allentown, PA 18103

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ _____
Patient or Guardian Name Date

Payment Policy

Our primary goal at our office is to establish a long-term, caring relationship with our patients. We participate with ***Delta Dental Premier*** insurance, but we do accept payment from all major dental insurances. Understanding your insurance benefit can be quite challenging. You will be expected to pay your **estimated portion** at the time of your visit. We will file your claim electronically with your insurance carrier. Please be aware we are only capable of approximating your portion of payment. Insurance companies periodically change benefits without notifying each dental office of these changes. Therefore, this office can only estimate your insurance reimbursement. Remember that no insurance company attempts to cover all dental costs.

Composite Restorations (White Fillings) on Molar Teeth

Dr. Schiffman routinely uses white filling material to restore teeth. We prefer to use this material for esthetic reasons, (white to match your tooth, as opposed to being silver or gray). It is a composite material which is chemically bonded to the tooth for strength and ease of repair.

Some insurance companies pay a percentage of these restorations, and some pay nothing at all. In most cases, they will pay a percentage or only pay the "alternate benefit" for an amalgam restoration on a molar teeth .

Payment Options

1. Cash – This includes money orders & personal checks.

2. Visa, MasterCard, Discover, & American Express

3. Citi Health Card – This option offers a seperate line of credit to cover large treatment or your entire family's healthcare needs. This credit line can be established & approval usually takes less than 10 minutes online or over the phone*Citi Health Card has an ***interest free option***. We promote **6** months & **12** months of no interest payments. There is no membership fee.

I hereby authorize Dr. Schiffman and his staff to release my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. Schiffman. I understand I am responsible for any unpaid balance.

I, ***the patient _____ , agree to pay any unpaid balance for the procedures regardless of Dr. Schiffman's participation with my insurance plan.***

_____Date _____

Signature of patient/Insured

Michael Schiffman, D.M.D.
1245 S. Cedar Crest Blvd., Suite 204
Allentown, PA 18103
(610)432-2841 fax (610)432-7820

Missed Appointment Policy

At Dr. Michael Schiffman's office , your scheduled appointment time is reserved just for you. We try not to overbook appointment times in order to provide excellent dental care and to be sure we have sufficient time to adequately examine you and to discuss your condition and treatment options in detail.

We will make every effort to accommodate your scheduling needs. In return, we ask that you help us by keeping your scheduled appointments, arriving on time and notifying us a minimum of twenty-four hours in advance if you are unable to do so. When we receive advance notice of cancellation, we are able accommodate other patients needing care. Failure to comply with this policy will necessitate the assessment of the following fees:

- **First missed appointment:** Our staff will call you to ensure you are all right and to reschedule your appointment.

- **Second missed appointment:** You will receive a letter stating this is your second missed appointment and that you have been charged a missed appointment fee ($75.00)

* **Third missed appointment:** A letter will be mailed informing you that you have now missed three appointments and you have been charged another missed appointment fee ($75.00)

* **Further missed appointments:** Further missed appointments will require pre-payment of your next dental visit at the time of scheduling. If you have dental insurance, you will be reimbursed that amount once insurance makes payment to the claim.

Please sign below that you have read and understand this policy.

Signature:_____

Date: _____