Welcome!

1 Patient Information

Name _____ Date _____

Social Security # _____ Birthdate _____

Wishes to be called: _____

2 Responsible Party

Who is responsible for the account?

Name _____ Relationship to patient _____

Birthdate _____

Social Security # _____

Address _____

City, State, Zip _____

Employer _____

Occupation _____

Home Phone # _____ Cell Phone # _____

Work Phone # _____ Ext. # _____

Where do you prefer to receive calls? ❑ Home ❑ Work ❑ Cell

When is the best time to reach you? Time _____ Days _____

In the event of an emergency, who should we contact? Name _____

Relationship _____ Home # _____ Work/Cell # _____

3 Dental Insurance Information

Primary Insurance

Name of Insured _____

Relationship to Patient _____

Insured's Birthdate _____

Soc. Sec. # _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group # _____

Employee / Cert. # _____

Ins. Co. Address _____

Additional Insurance

Name of Insured _____

Relationship to Patient _____

Insurec's Birthdate _____

Soc. Sec. # _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group # _____

Employee / Cert. # _____

Ins. Co. Address _____

4 No Show Fee / Cancellation Policy

It is our understanding that interruptions to our schedules occur and we appreciate that we are subject to issues of family, health, and emergencies of multiple proportions. However, our time is scheduled in order to focus upon your oral health concerns.

The team at our offices makes every effort to make your time at our office pleasant and productive. We take pride in that our appointments are most efficient and that we make our best effort to not subject you to lengthy waits in our reception area. We wish to make appointments that will accommodate multiple family members at one visit and provide services that will allow for your best comfort.

All appointments, when made, have a specific date and time of day, in order that you are able to gauge your valuable time.

If you are not able to meet your appointment, we request a 24-hour notification.

As a courtesy, we will attempt to remind you of the appointment that you made.

As per the office policy, I understand that if I cancel an appointment without 24-hour notice and/or no show to an appointment, a fee will be charged to my account.

Name _____

Signature _____

Date _____

Madeline Shakin, D.D.S.
Kevin Sheren, D.D.S., P.C.
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Fax (631) 581-3909

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Madeline Shakin DDS Kevin Sheren DDS PC

369 East Main Street, Suite 9, East Islip, NY 11730 (631)581-1188

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Height: _____ Weight: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell): _____ (Work) _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact: _____ Relationship: _____ Phone: _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

- Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No
  If yes, please explain: _____

Have you ever had any of the following? Please check those that apply:

☐ Allergies _____

_____

☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes Type I or II
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ High Cholesterol
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur/MVP
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date: _____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Reflux
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Smoking

OTHER:
☐ _____
☐ _____

- Name of Physician: _____ Phone: _____
- Have you been admitted to a hospital or needed surgery during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you taking or have you taken any prescription or over the counter medicine(s)?
  If so, please list all: _____
  _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

MADELINE SHAKIN, DDS, KEVIN SHEREN, DDS, PC
369 East Main Street, Ste 9, East Islip, NY 11730 (631) 581-1188

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone:_____SS#_____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carr treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Co Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may r protected health information, and of other important matters about your protected health information. A copy of our Notice is avai request. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy prac issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected hea information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at anytime by contacting: Madeline Shakin, DDS, Kevin Sheren, DDS, PC, 369 East Main Street, Ste 9, East Islip, NY 11730 (631) 581-1188

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submi contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I,_____, have had full opportunity to read and consider the contents of this Consent fo Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of health information to carry out treatment, payment activities, and healthcare operations.

Signature:_____Date:_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____Date:_____

You Are Entitled To A Copy Of This Consent After You Sign It

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthc operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you r written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Cc

Signature:_____Date:_____

RELEASE OF INFORMATION TO PARENT/SPOUSE/THIRD PARTY

The following individuals are authorized by me to discuss or receive information regarding my health or dental treatment:

Name:_____Relationship:_____

Name:_____Relationship:_____

Signature:_____Date:_____