



**Billing Information**

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Birth Date \_\_\_\_\_ Marital Status \_\_\_\_\_ Soc.Sec.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 E-mail \_\_\_\_\_ Sex \_\_\_\_\_ Local 456: Municipality or Teamsters  
 Town of \_\_\_\_\_

Name of Responsible Party \_\_\_\_\_  
 Billing Address \_\_\_\_\_

Referred By \_\_\_\_\_ Full Time Student? School \_\_\_\_\_

**Primary Insurance**

Employee Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Soc. Sec # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship: Spouse Child Self Other  
 Employer Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company Name \_\_\_\_\_  
 & Address \_\_\_\_\_  
 \_\_\_\_\_

Group # \_\_\_\_\_ Employee ID # \_\_\_\_\_  
 Phone \_\_\_\_\_

**Secondary Insurance**

Employee Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Soc. Sec # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship: Spouse Child Self Other  
 Employer Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company Name \_\_\_\_\_  
 & Address \_\_\_\_\_  
 \_\_\_\_\_

Group # \_\_\_\_\_ Employee ID # \_\_\_\_\_  
 Phone \_\_\_\_\_

**Survey**

How did you hear about us?  
 TV Ad \_\_\_ Internet \_\_\_ Personal Referral \_\_\_ Doctor Referral \_\_\_ Ins. Referral \_\_\_ Other \_\_\_\_\_

If you said "Internet", What did you search? \_\_\_\_\_

If you said "Internet", Which search engine did you use?  
 Google \_\_\_ MSN \_\_\_ Yahoo! \_\_\_ Other \_\_\_\_\_



**Health History**

1. Are you in good health? Yes No
2. Are you currently under medical care? Yes No
  - a. Physician's Name \_\_\_\_\_
  - b. Phone # \_\_\_\_\_
3. Have you been hospitalized in the past 5 years? Yes No
  - a. Please Explain \_\_\_\_\_
4. Have you had any serious illnesses or operations? Yes No
  - a. Please Explain \_\_\_\_\_
5. Please list all Medications you take DAILY:
  - a. Name \_\_\_\_\_ Name \_\_\_\_\_
  - b. Name \_\_\_\_\_ Name \_\_\_\_\_
  - c. Name \_\_\_\_\_ Name \_\_\_\_\_
  - d. Name \_\_\_\_\_ Name \_\_\_\_\_
  - e. Name \_\_\_\_\_ Name \_\_\_\_\_
6. Do you have, or have you had any of the following?
  - a. Heart Disease? Yes No
  - b. High Blood Pressure? Yes No
  - c. Blood Disorder or Anemia? Yes No
  - d. Rheumatic Fever or Heart Murmur? Yes No
  - e. A Subacute Bacterial Endocarditis (SBE) Infection? Yes No
  - f. Unrepaired Congenital Heart Defect (CHD)? Yes No
  - g. Repaired CHD within 6 mos or one that is still leaking? Yes No
  - h. A Heart Transplant? Yes No
  - i. Artificial Heart (Cardiac) Valve? Yes No
    1. When was it place \_\_\_\_\_
  - j. Artificial Hip, Knee or Joint Replacement? Yes No
    1. When was it placed? \_\_\_\_\_
  - k. Previous Infection in an Artificial Valve, Hip, Knee or Joint? Yes No
  - l. Diabetes? Yes No
  - m. Stroke? Yes No
  - n. Epilepsy or Seizures? Yes No
  - o. Fainting Spells? Yes No
  - p. Psychiatric Treatment? Yes No
  - q. Cancer or Tumors? Yes No
  - r. Venereal Disease? Yes No
  - s. Radiation or Chemotherapy? Yes No
  - t. Liver or Kidney Disease? Yes No
  - u. Hepatitis or Jaundice? Yes No
  - v. AIDS or HIV Positive? Yes No
  - w. Bleeding Disorder or Prolonged Bleeding? Yes No
  - x. Asthma? Yes No
  - y. Tuberculosis or Emphysema? Yes No

7. Have you ever had an Allergy to any medications? Yes No
- a. Please list all Allergies and type of reaction you had to that medication:
- |               |                |
|---------------|----------------|
| 1. Drug _____ | Reaction _____ |
| 2. Drug _____ | Reaction _____ |
| 3. Drug _____ | Reaction _____ |
| 4. Drug _____ | Reaction _____ |
8. Are you presently taking Aspirin, Coumadin or any Anticoagulant? Yes No
9. Have you ever had a reaction to a Local Anesthetic or Novocain? Yes No
10. Have you ever had an allergy to Nickel or any other Metals? Yes No
11. Do you Smoke? Yes No
12. Are you currently taking or have you ever taken Fosamax, Zometa, Zoledronate, Aredia or Pamidronate? Yes No
13. Are you Pregnant? Yes No
14. DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED? Yes No
- a. Please Explain \_\_\_\_\_

**Financial Consent for Services**

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within ten (10) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Louis B. Colletti, D.D.S. & Eric D. Cook, D.D.S., LLP

**Acknowledgement of Receipt of Notice of  
Privacy Practices**

\* You may refuse to sign this acknowledgement\*

I, \_\_\_\_\_, have

received a copy of this office's Notice of Privacy Practices,  
available upon request and posted in the waiting room.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**  
**SECTION A: PATIENT GIVING CONSENT**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ E-mail \_\_\_\_\_

**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 carry out 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 Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request and is posted in our waiting room for you to view. 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 practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by asking or contacting:

Contact Person: Eric D. Cook, D.D.S.  
Telephone: (845) 628-8196 Fax: (845) 628-2889  
E-mail: office@colletticook.com  
Address: 572 Route 6 Mahopac, NY 10541

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent 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 form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care 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: \_\_\_\_\_

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.