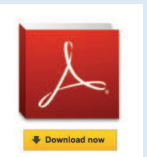
Central Park West Dentistry
25 W. 68th Street, Suite 1A
New York, NY 10023
866.868.9546
nyc.dentist@verizon.net
www.cpwdentistry.com



Download a free copy of Adobe Reader® here to fill out this interactive form.

PATIENT FORM AND HEALTH HISTORY

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form on your computer using Adobe Acrobat Reader® or Acrobat Professional®. See link above. Please do not use Mac Preview.

1) Complete, sign, print and fax this form to **212-579-8881** ***OR***

2) Attach completed pdf to our email address **nyc.dentist@verizon.net** and send. Call us if you have questions.

Patient Information

Date (MM/DD/YR)_____

Name (LAST, FIRST, MIDDLE INITIAL) _____ Social Security #_____

Preferred Name _____ Driver's License #_____

❑ Male ❑ Female ❑ Married ❑ Widowed ❑ Single ❑ Minor

Birthdate (MM/DD/YR)_____ ❑ Separated ❑ Divorced ❑ Partnered for ____ years

Address (STREET, CITY, STATE, ZIP) _____

Email Address _____

Home Phone #_____ Cell Phone #_____ Work # _____

Who may we thank for referring you? _____

In case of emergency, who should be notified? Name _____ Phone # _____

Patient Occupation_____

Patient Employer/School _____

Employer/School Address _____

List one special thing you'd like us to know about you _____

Primary Insurance

Name of Subscriber (LAST, FIRST, MIDDLE INITIAL) _____

Relation to Patient: ❑ Self ❑ Other_____ Birthdate (MM/DD/YR) _____ Social Security # _____

Address (if different from patient's) _____

Home Phone #_____ Cell Phone #_____ Work # _____

Subscriber Employed By _____ Occupation _____

Business Address (STREET, CITY, STATE, ZIP) _____

Business Phone Number _____

Insurance Company Name _____ Insurance Company's Phone #_____

Subscriber ID #_____ Group # _____

Names of other dependents covered under this plan _____

Secondary Insurance

Name of Subscriber (LAST, FIRST, MIDDLE INITIAL) _____

Relation to Patient _____ Birthdate (MM/DD/YR) _____ Social Security # _____

Address (if different from patient's) _____

Home Phone #_____ Cell Phone #_____ Work # _____

Subscriber Employed By _____ Occupation _____

Business Address (STREET, CITY, STATE, ZIP) _____

Business Phone Number _____

Insurance Company Name _____ Insurance Company's Phone #_____

Subscriber ID #_____ Group # _____

Names of other dependents covered under this plan _____

(continued >>)

CPW DENTISTRY

PATIENT FORM AND HEALTH HISTORY (continued)

Dental History

Reason for today's visit _____

Date of last dental care _____ Date of last dental x-rays _____

Former dentist (NAME, PHONE, CITY, STATE)

_____

Check if you have problems with the following:

❑ Bad Breath	❑ Bleeding Gums	❑ Clicking or Popping Jaw
❑ Food Collection Between Teeth	❑ Grinding Teeth	❑ Loose Tooth or Broken Fillings
❑ Periodontal Treatment	❑ Sensitivity to Cold	❑ Sensitivity to Hot
❑ Sensitivity to Sweets	❑ Sensitivity When Biting	❑ Sores or Growths in Your Mouth

How often do you floss? _____ How often do you brush? _____

On a scale of 1-10 (1 being poor/10 being excellent), how would you rate your smile? _____

If you could change one thing about your smile, what would it be? _____

Medical History

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "FEN-PHEN?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) ❑ Yes ❑ No

Have you had any serious illnesses or operations? ❑ Yes ❑ No If yes, describe _____

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, give approximate date(s) _____

How are you feeling today? _____

WOMEN:

Are you pregnant? ❑ Yes ❑ No

Nursing? ❑ Yes ❑ No

Taking birth control pills? ❑ Yes ❑ No

Check (✔) if you have or have had any of the following:

❑ Anemia	❑ Chemotherapy	❑ Headaches	❑ Liver Disease	❑ Sleep Apnea
❑ Arthritis, Rheumatism	❑ Circulatory Problems	❑ Heart Murmur	❑ Mitral Valve Prolapse	❑ Stroke
❑ Artificial Heart Valves	❑ Cortisone Treatments	❑ Heart Problems	❑ Pacemaker	❑ Swelling of Feet or Ankless
❑ Artificial Joints	❑ Cough, Persistent	❑ Hemophilia	❑ Radiation Treatment	❑ Thyroid Problems
❑ Asthma	❑ Cough Up Blood	❑ Hepatitis	❑ Respiratory Disease	❑ Tobacco Habit
❑ Back Problems	❑ Diabetes	❑ High Blood Pressure	❑ Rheumatic Fever	❑ Tonsillitis
❑ Blood Disease	❑ Epilepsy	❑ HIV/AIDS	❑ Scarlet Fever	❑ Tuberculosis
❑ Cancer	❑ Fainting	❑ Jaw Pain	❑ Shortness of Breath	❑ Ulcer
❑ Chemical Dependency	❑ Glaucoma	❑ Kidney Disease	❑ Skin Rash	❑ Venereal Disease
				❑ Other _____

MEDICATIONS

Please list any medications you are currently taking: _____

ALLERGIES _____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____(name of insurance carrier(s) and assign directly to Dr. _____ and Central Park West Dentistry, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

1) _____ _____

Sign, print and fax to 212-579-8881 (Patient, Parent, Guardian or Personal Representative) Date (MM/DD/YR)

OR

2) _____ _____

Type in initials, attach completed pdf to email and send to nyc.dentist@verizon.net (Patient, Parent, Guardian or Personal Representative) Relationship to Patient

CPW DENTISTRY

Central Park West Dentistry
25 W. 68th Street, Suite 1A
New York, NY 10023

866.868.9546
nyc.dentist@verizon.net
www.cpwdentistry.com

Central Park West Dentistry Office Policies

PLEASE BE CONSCIENTIOUS WITH YOUR APPOINTMENTS

- The doctor reserves each appointment just for you. We do not over book so please be on time. If you must change your appointment please call 48 hours in advance.
- Appointments that are broken or cancelled with short notice will be subject to an initial broken appointment fee of $75.00 per hour of time reserved.
- 100% of all broken appointment fees are donated to the St. Jude's Children's Research Hospital.
- We will make every effort to contact you to confirm your appointment well in advance, however if you have not responded to confirm, we may need to give your appointment to another patient with a dental need.

PAYMENT IS EXPECTED THE DAY SERVICE IS RENDERED

- We accept cash, money order, certified check, credit cards, Visa/MasterCard, Discover, and American Express. Our Health Care Incentive Program will enable you to use your credit card for automatic billing.
- We offer convenient interest free financing through Care Credit.
- Patients that prepay treatment of over $1000.00 will receive a 10% discount.

DENTAL INSURANCE

- We accept most plans towards payment.
- Co-payment is due at time of treatment.
- If needed, we will obtain a summary of your insurance benefits from your insurance company and review it with you.
- Our office will make sure we maximize your benefits.
- Balances due over 30 days will be subject to a finance charge of 2.0% compounded monthly with a minimum finance charge of $2.50.

Payment Arrangements

WE SUBMIT INSURANCE CLAIMS as a courtesy to all our patients, however, any portion that the insurance does not cover is the patient's responsibility. For this reason it is our policy to have an active credit card on file for each patient in the event the insurance does not cover the visit in full.

We will exhaust all efforts to contact you regarding your balance but if we cannot contact you within 90 days, we are authorized to charge your credit card for the remaining balance.

❒ Check here if you'd like your balance to be deducted automatically after insurance has paid.

PAYMENT ARRANGEMENTS INCLUDING PAYMENT PLANS MAY BE MADE UPON REQUEST OF THE PATIENT

Cardholder Signature:

1) _____ _____

Sign, print and fax to 212-579-8881 (Patient, Parent, Guardian or Personal Representative) — Date (MM/DD/YR)

OR

2) _____ _____

Type in initials, attach completed pdf to email and send to nyc.dentist@verizon.net (Patient, Parent, Guardian or Personal Representative) — Relationship to Patient

Print Name of Patient Below:

X_____Date_____

❒ Visa ❒ MasterCard ❒ Discover ❒ AmExpress Credit Card Account #_____

Exp. Date_____ Sec. Code_____

Name on Card_____

Billing Address_____Zip Code_____

CPW DENTISTRY

Central Park West Dentistry
25 W. 68th Street, Suite 1A
New York, NY 10023

866.868.9546
nyc.dentist@verizon.net
www.cpwdentistry.com

HIPAA Policy

John F. Lhota, DMD
Central Park West Dentistry, PC

Notice of Privacy Practices: Use and Disclosure of Health Information Protected under HIPAA
Effective April 14, 2003

This document provides a summary of how health care information about you may be used and disclosed and how you can obtain access to this information.

We understand that information about you and your health is personal. We are committed to protecting your health information. It is our policy that the privacy of your protected health information (PHI) not be compromised while still allowing necessary access to assure that the health care you receive is appropriate and of the highest possible quality.

We pledge to you that we will protect the confidentiality of information provided to us. Your information will be used in the following manner, known as Treatment, Payment, and Healthcare Operations (TPO):

1. To provide dental treatment and/or services.
2. To facilitate payment by third party payers, when appropriate, for health care treatment you receive.
3. To facilitate the mechanisms which allow the operation of our facility.

In every use of your information, we will be responsible custodians of your PHI and adhere to the standards set forth in the legislation, which created these privacy practices. We recognize that all patients have the right to privacy in matters relating to their health, and we will not use your PHI for uses other than TPO related to health care without your express permission.

You have the following rights regarding the medical information we maintain about you:

1. Access, upon request, to information that may be used to make decisions about your care.
2. To request restrictions or limitations on the PHI we disclose about you for treatment, payment or health operations. While we are not required to agree to your request, if we do agree, we will comply with the restrictions unless the information is needed to provide emergency treatment.
3. To request that we amend the PHI we maintain about you if you believe that the information we have about you is incorrect or incomplete.
4. To request an accounting of disclosures we have made for uses other than our own.
5. To request confidential communications; i.e., that we communicate with you in a certain manner or at a certain location.
6. To receive a paper copy of this notice.

All members of our staff are committed to adhering to the conditions set forth in this notice of privacy practices. Any violation will be grounds for disciplinary action. We reserve the right to change this policy in the future; such changes will be available to all patients.

Should you believe that your privacy rights have been violated, you may file a complaint with this facility or with the State oversight department; all complaints must be submitted in writing. You will not be penalized for filing a complaint.

Patient acknowledgement: I acknowledge receipt of this information regarding my right to PHI privacy.

1) _____ _____

Sign, print and fax to 212-579-8881 (Patient, Parent, Guardian or Personal Representative) Date (MM/DD/YR)

OR

2) _____ _____

Type in initials, attach completed pdf to email and send to nyc.dentist@verizon.net
(Patient, Parent, Guardian or Personal Representative) Relationship to Patient

CPW DENTISTRY

Central Park West Dentistry
25 W. 68th Street, Suite 1A
New York, NY 10023

866.868.9546
nyc.dentist@verizon.net
www.cpwdentistry.com

Consent Form for General Dental Procedures

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence. Some of the more commonly known risks and complications of treatment include, but are not limited to the following: pain, swelling, and discomfort after treatment; infection in need of medication or other treatment; numbness, pain, tingling or altered sensation of the lip, face, chin, gums and tongue along with the possible loss of taste; damage to adjacent teeth, restorations or gums; possible deterioration of condition which may result in tooth loss; the need for replacement of restorations, implants, or other appliances in the future; an altered bite in need of adjustment; possible injury to the jaw joint and related structures requiring follow-up care; a root tip, bone fragment, or piece of a dental instrument may be left in the body and need to be removed at a later time if symptoms develop; jaw fracture; sinus infection or opening between the mouth and sinus cavity resulting in infection or need for further treatment; allergic reaction to anesthetic or medication; need for follow-up treatment, including surgery.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialist, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist. If a procedure that was originally done in our office needs to be redone, as long as you maintain regular recall with our office and follow all instructions so your dental health may be maintained, we are happy to redo the procedure at no cost to you.

Further, I understand that I am entering into a contractual relationship with Dr. Lhota/Central Park West Dentistry for professional care. I further understand that meritless and frivolous claims for dental malpractice have an adverse effect upon the cost and availability of dental care, and may result in irreparable harm to a dental provider. As additional consideration for professional care provided to me by Dr. Lhota/Central Park West Dentistry, I, agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical/dental malpractice against Dr. Lhota, Central Park West Dentistry, P.C. , and their associates.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain **all of your concerns have been addressed to your satisfaction by your dentist** before commencing treatment.

1) _____ _____

Sign, print and fax to 212-579-8881 (Patient, Parent, Guardian or Personal Representative) Date (MM/DD/YR)

OR

2) _____ _____

Type in initials, attach completed pdf to email and send to nyc.dentist@verizon.net
(Patient, Parent, Guardian or Personal Representative) Relationship to Patient

_____

Type/Print Patient Name