THE FOLLOWING CONTAINS A COMPLETE LIST OF GENERAL PATIENT INFORMATION, MEDICAL HISTORY, DENTAL HISTORY, CONSENT TO TREATMENT, AND ACKNOWLEDGEMENT OF HIPAA FOR THE PURPOSES OF ACCURATE, OBLIGING, AND BENEFICIAL DENTAL TREATMENT TO THE PATIENT.

JOSEPH LICHTER D.D.S. OFFICE PLEDGE:
While creating beautiful smiles, we will give our patients the confidence to take the first step by always going the extra mile.

Please Flip to Begin Forms↷

JOSEPH LICHTER D.D.S.,P.C. | 1420 AVENUE P, BROOKLYN, NEW YORK 11229 | 718-339-7878

GENERAL PATIENT INFORMATION

ALL INFORMATION GIVEN WILL BE KEPT CONFIDENTIAL

LEGAL FULL NAME	FIRST	M.	LAST
GENDER: ☐ MALE ☐ FEMALE ☐ OTHER:_____		DATE OF BIRTH: (MONTH/DAY/YEAR)	
SS#/SIN	STATUS: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ NOT LISTED		
ADDRESS			APT #
CITY	STATE/PROV.	ZIP CODE/P.C.	
Referral; Who may we thank for referring you?	☐ Family	☐ Friend	☐ Online ☐ Other _____

CONTACT INFORMATION

USED TO CONTACT PATIENT FOR APPOINTMENT. WILL NOT BE GIVEN TO ANY OUTSIDE ORG./SOURCE.

CELL PHONE	HOME PHONE	EMAIL

EMERGENCY CONTACT INFORMATION

RELATION TO THE PATIENT:

FULL NAME:	FIRST	M	LAST
CELL PHONE:	HOME PHONE:	WORK PHONE:	

RESPONSIBLE PARTY INFORMATION

FULL LEGAL NAME: FIRST MIDDLE LAST

RELATION TO PATIENT	DATE OF BIRTH: (MONTH/ DAY/YEAR)	
CELL PHONE:	HOME PHONE:	EMAIL
ADDRESS		APT #
CITY	STATE/PROV.	ZIP CODE/P.C.

PHARMACY INFORMATION (FOR PRESCRIPTIONS)

ADDRESS		
CITY	STATE/PROV.	ZIP CODE/P.C.
PHONE	FAX	EMAIL

INSURANCE

INSURANCE:	PATIENT ID#:
GROUP # (IF APPLICABLE)	INSURANCE PHONE:
☐ POLICY HOLDER IS GUARDIAN ☐ POLICY HOLDER IS SPOUSE ☐ OTHER_____	☐ **POLICY HOLDER IS PATIENT** (IF PATIENT IS POLICY HOLDER, DO NOT FILL OUT POLICY HOLDER INFORMATION BELOW)

POLICY HOLDER INFORMATION	FIRST	M.	LAST
POLICYHOLDER BIRTHDAY:		POLICY HOLDER ID#:	

(PLEASE SIGN HERE)_____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR DATE

Continue to PATIENT MEDICAL HISTORY↷

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PATIENT MEDICAL HISTORY

PATIENT FULL NAME	DOB: / /

QUESTIONS REGARDING MEDICAL HEALTH:	YES	NO
ARE YOU IN GOOD HEALTH?		
HAVE YOU HAD A DRAMATIC CHANGE IN HEALTH IN THE PAST YEAR?		
DO YOU HAVE A PHYSICIAN?		
HAVE YOU EVER BEEN HOSPITALIZED FOR SERIOUS ILLNESS OR SURGICAL OPERATION?		

DATE OF LAST PHYSICAL EXAM? _____/_____/_____ PHYSICIAN PHONE: _____-_____-_____
PHYSICIAN NAME:_____ PHYSICIAN ADDRESS:_____

DO YOU HAVE A DISEASE, CONDITION, OR PROBLEM YOU WOULD LIKE US TO KNOW ABOUT? **IF YES, PLEASE WRITE ON THE PROVIDED MEDICATION SLIP.**		
ARE YOU CURRENTLY TAKING ANY MEDICATION INCLUDING NON-PRESCRIPTION MEDICINE? **IF YES, PLEASE WRITE ON THE PROVIDED MEDICATION SLIP.**		

ALLERGIES	YES	NO
LOCAL ANESTHETICS LIKE LIDOCAINE?		
PENICILLIN, OR ANOTHER ANTIBIOTIC?		
SULFA DRUGS (BACTRIM, CIPRO,..)?		
BARBITURATES, SEDATIVES, OR SLEEPING PILLS?		
ANY METALS (NICKEL, MERCURY, ETC…)?		
ASPIRIN?		
IODINE?		
LATEX/RUBBER?		
OTHER.?		

MEDICATIONS		
HAVE YOU EVER TAKEN ANY OF THESE:	YES	NO
FEN-PHEN/REDUX		
Bone-loss prevention drugs: FOSAMAX, ACTONEL, BONIVA		
CANCER MEDICATIONS		
BISPHOSPHONATES		
HERBAL/HOMEOPATHIC SUPPLEMENTS	*	
VITAMIN OR MINERAL SUPPLEMENTS	*	
DO YOU TAKE ANY OF THESE?	YES	NO
VIAGRA		
REVATIO		
CIALIS		
LEVITRA/STAXYN		

WOMEN ONLY	YES	NO
ARE YOU PREGNANT?		
ARE YOU POTENTIALLY PREGNANT?		
ARE YOU NURSING?		
ARE YOU TAKING BIRTH CONTROL PILLS?		

CHECK THE BOX ON THE RIGHT IF YOU HAVE ANY OF THESE:

RHEUMATIC HEART DISEASE		SCARLET FEVER	
AIDS OR HIV INFECTION		CHEST PAIN	
HEART DEFECT OR HEART MURMUR		PACEMAKER	
HEART TROUBLE, HEART ATTACK, ANGINA		HEART SURGERY	
HIGH/LOW BLOOD PRESSURE		STROKE	
SHORTNESS OF BREATH		DIABETES	
HEPATITIS, JAUNDICE, LIVER DISEASE		ALLERGIES	
ASTHMA, HAY FEVER, HIVES, SKIN RASH; (IF YES, WHICH)		TUBERCULOSIS	
LUNG OR BREATHING PROBLEMS		KIDNEY TROUBLE	
FAINTING OR DIZZINESS		ANEMIA	
JOINT REPLACEMENT OR IMPLANT		GLAUCOMA	
CHEMOTHERAPY (CANCER OR LEUKEMIA)		TUMORS	
MITRAL VALVE PROLAPSE		COLD SORES	
MENTAL HEALTH CARE		FEVER BLISTERS	
ANY NON-LISTED CONDITION:		EATING DISORDERS	

(PLEASE SIGN HERE)_____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR **DATE**

Please Flip to MEDICATION SLIP↷

Medication Record Slip:

PATIENT FULL NAME: DOB:

Kind of Doctor who Prescribed Medication	Name of Doctor who Prescribed Medication	Phone Number/Contact info

Please list any Prescribed Medications, Over the Counter Drugs, Herbal Remedies, Regular Doses of Aspirin, Weight Loss or Diet Pills, Vitamin or Mineral Supplements such as Ephedra, Garlic, Ginkgo, Ginseng, Kava, St.John's Wort, Valerian Root, Vitamin E, and/or any other medications.

Name of Medication:	Reason for Taking Medication:
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Misreporting Medications or leaving off medications is dangerous for the health of the patient. Please sign below to acknowledge that you know the dangers of misreporting Medications to a healthcare provider and have provided only truthful and accurate information to the best fo your ability.

(PLEASE SIGN HERE)_____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR DATE

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Please Flip to DENTAL HISTORY↷

PATIENT DENTAL HISTORY

PATIENT FULL NAME:	DOB: / /
WHEN WAS YOUR LAST DENTAL VISIT? / /	**REASON FOR VISIT:**
PREVIOUS DENTIST NAME AND LOCATION:	
HOW OFTEN DID YOU VISIT THE DENTIST?	☐ Every 6 months ☐ As needed ☐ Other_____
HOW OFTEN DO YOU BRUSH YOUR TEETH?	☐ 2 times a day ☐ Once a day ☐ Other_____
HOW OFTEN ARE YOU FLOSSING?	☐ Morning and Night ☐ At appointments ☐Other_____

CHECK YES/NO FOR THE FOLLOWING:	YES	NO	PLEASE CONTINUE, CHECK YES/NO FOR THE FOLLOWING:	YES	NO
ARE YOUR TEETH SENSITIVE TO THESE?			DO YOUR GUMS BLEED WHILE FLOSSING?		
HOT AND COLD LIQUIDS OR FOODS?			DO YOU HAVE SORES OR LUMPS IN YOUR MOUTH?		
SWEET AND SOUR LIQUIDS OR FOODS?			HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS?		
DO YOU FEEL PAIN IN YOUR MOUTH?			HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?		
DO YOU HAVE FREQUENT HEADACHES?			HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS FOR YOUR TEETH OR GUMS?		
DO YOU EXPERIENCE ANY OF THESE IN YOUR JAW?			HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?		
CLICKING			HAVE YOU HAD HEAD, NECK, OR JAW INJURIES?		
PAIN (JOINT, EAR, SIDE OF FACE)			HAVE YOU NOTICED LOOSENING OF YOUR TEETH?		
DIFFICULTY OPENING OR CLOSING			DOES FOOD TEND TO GET STUCK IN YOUR TEETH?		
DIFFICULTY CHEWING			HAVE YOU HAD PERIODONTAL TREATMENT (GUMS?)		
HAVE YOU EVER DONE AT-HOME COSMETICS?			HAVE YOU EVER HAD PROSTHETICS OR REMOVEABLES?		
WHITENING GEL PEN OR TRAYS?			HAVE YOU EVER HAD A DENTURE OR PARTIAL?		
LIP PLUMPERS			IF YES, WHAT KIND/WHEN? _____.		
FACIAL SKIN SERUM/TIGHTENING			HAVE YOU EVER HAD/CONSIDERED COSMETIC DENTISTRY?		

WHAT CAN WE DO TO HELP YOU LOVE YOUR SMILE? _____

AUTHORIZATION AND RELEASE:

I CERTIFY I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE ANSWERED QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYERS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

SIGNATURE OF PATIENT OR PARENT/GUARDIAN

X._____

CONTINUE TO CONSENT FORMS

CONSENT TO DENTAL TREATMENT

1. I hereby authorize a doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (PRINT PATIENT FULL NAME)_____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by myself and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

PATIENT(PLEASE PRINT) _____ DATE_____

(PLEASE SIGN HERE) _____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR **DATE**

PATIENT OR RESPONSIBLE PARTY SIGNATURE:_____ DATE_____

RELATIONSHIP TO PATIENT:_____ DATE_____

DENTIST CERTIFICATION:

I hereby certify that I have explained the nature, purpose, benefits, risk of, and alternatives (including no treatment and attendant risks.), to ANY AND ALL FUTURE proposed procedure(s). I have and will offer answers to any questions and have fully answered all such questions. I believe that the patient/parent/guardian fully understands what I have explained and answered.

DOCTORS OF DENTAL SURGERY:

JOSEPH LICHTER D.D.S, P.C. DENTIST SIGNATURE:_____

VICTORIA FAYNSHTAYN D.D.S.

RACHEL KLEIN D.D.S. DATE:_____

HIPAA PATIENT CONSENT FORM

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT

I understand that, under the health insurance portability & accountability act of 1996 (HIPAA), I have certain rights of 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 have been informed by you of your *Notice Of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice Of Privacy* practices prior to signing the consent. 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 below 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 healthcare 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.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (PRINTED)_____ DATE:_____

Patient or Guardian Name (**SIGN HERE**) _____ DATE:_____

(IF GUARDIAN) Relationship to the Patient:_____ DATE:_____

JOSEPH LICHTER
D.D.S.

THANK YOU FOR COMPLETING YOUR NEW PATIENT FORMS
FOR JOSEPH LICHTER D.D.S.!

WE ARE SO HAPPY THAT YOU HAVE JOINED THE FAMILY.