Leonid Portugeys DDS

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Get Acquainted Questionnaire

In order for us to better serve you, please fill out the following information **COMPLETELY**

Name: _____
(first) (middle) (last) (preferred)

Address: _____
(number & street) (city) (state) (zip code)

Social Security #:_____ Date of Birth:_____ Home

Telephone: _____ Business Telephone:_____

Email:_____ Cell Phone:_____

Employer:_____ Occupation:_____ Whom

may we thank for referring you? _____

Are you married? Yes ___ No ___ Spouse's name: _____

Emergency Contact

Name:_____ Phone Number:_____

Relationship to Patient:_____

For Patients with Dental Insurance

Primary Insurance

Insurance Carrier: _____ Group #: _____
Name of Insured: _____ Relationship to Patient:_____ SS#(or ID#) _____ DOB:_____
(if different from above)

Secondary Insurance

Insurance Carrier: _____ Group #: _____
Name of Insured: _____ Relationship to Patient:_____
SS#(or ID#) _____ DOB:_____
If patient is a student – Name of school: _____

I hereby authorize Dr Leonid Portugeys to release to _____ or its representative, and information including the diagnosis and the (Name of Insurance Company)
records of any treatment or examination rendered to me during the period of such Dental care. I also authorize and request your company pay directly to Dr Leonid Portugeys the amount due to me in my pending claim for dental treatment or services, by reason of such treatment or services rendered.

Signature of Insured: _____ Date: _____

MEDICAL HISTORY

Are you currently under the care of a physician? No ____ Yes ____ Please explain _____
_____
Are you taking any prescription/over the counter drugs? No____ Yes ____ Please list each one _____
_____
For Women: Do you take any form of birth control? No ____ Yes ____ Which kind? _____
Are you pregnant? No ____ Yes ____ How many weeks? _____
Are you nursing? No ____ Yes ____

Do you have or have you ever had any of the following diseases or medical problems? **If NO, please circle NO**

Y N Heart Attack	Y N Stroke	Y N Cancer
Y N Chemotherapy	Y N Heart Murmur	Y N Heart Defect
Y N Rheumatic Fever	Y N HIV	Y N AIDS
Y N Heart Surgery	Y N Crohn's Disease	Y N Hepatitis
Y N Pacemaker	Y N Shingles	Y N Mitral Valve Prolapse
Y N Kidney Problems	Y N Artificial Bones, Joints	Y N Artificial Valves
Y N Sinus Problems	Y N High Blood Pressure	Y N Low Blood Pressure
Y N Fever Blisters	Y N Blood Transfusion	Y N Migraines
Y N Psychiatric Problems	Y N Epilepsy	Y N Seizures
Y N Fainting Spells	Y N Diabetes	Y N Tuberculosis(TB)
Y N Venereal Disease	Y N Hemophilia	Y N Abnormal Bleeding
Y N Ulcers	Y N Colitis	Y N Anemia
Y N Radiation Treatment	Y N Asthma	Y N Arthritis
Y N Difficulty Breathing	Y N Hospitalized	
Y N Glaucoma	Y N Emphysema	

Please list any other serious medical condition(s) that you may have ever had: _____
_____
Are you allergic to any of the following drugs? **If No, please circle NO**

Y N Penicillin	Y N Tetracycline	Y N Latex
Y N Aspirin	Y N Codeine	Y N Ibuprofen
Y N Erythromycin	Y N Dental Anesthetics	Y N Sulfa Drugs

Please list any other drugs that you are allergic to:
_____

DENTAL HISTORY

Have you ever had a serious problem associated with any previous dental work? No ____ Yes ____
Have you ever experienced pain/discomfort in your jaw (TMJ/TMD)? No ____ Yes ____
Do you like your smile? No ____ Yes ____
Do your gums ever bleed? No ____ Yes ____
How many times a week do you floss? _____
How many times a day do you brush? _____

I affirm that the information that I have given today is correct to the best of my knowledge. I understand that Dr Leonid Portugeys safeguards my information in accordance with the HIPPA guidelines. I also understand that it's my responsibility to inform the office of any changes in my medical history.

I authorize, with informed consent Dr Leonid Portugeys to perform any necessary dental services to help maintain my oral health, including diagnosis and treatment.

Signature_____
Date_____

Financial Policy

Dr Leonid Portugeys strives to be punctual, therefore we ask that our patients keep their appointments and also arrive on time. If a patient must cancel an appointment, we require at least 24 hours notice.

Dr Leonid Portugeys will make every effort possible to assist our patients with their insurance, however please keep in mind that dental insurance is a contract between the insurance company and the patient, not the dental provider. It is up to the patient to fully understand his/her benefits to ensure the appropriate disbursement of benefits under the terms of each individual plan.

It is the patient's responsibility to notify Dr Leonid Portugeys should there be any change in the insurance plan. It is also the patient's responsibility to notify us of any dental procedures that have been done in **other** dental offices that may reduce the insurance benefits available for the year.

As a courtesy to our patients, Dr Leonid Portugeys provides a treatment plan of which includes an estimate of the recommended treatment, the expected coverage from the dental coverage as well as the patient's copayment respectively. **Benefits quoted to you are only an estimate provided by the insurance company and not a guarantee of payment or eligibility at the time the services are performed.** Dr Leonid Portugeys will submit claims and accept the assignment of benefits from the insurance company on behalf of the patient provided the patient pays their co-payment for each visit, due at the time of treatment, unless prior arrangements have been made.

In the event that the claim is not paid by the insurance company within 30 days, the balance becomes the patient's responsibility and is due immediately. Any balances that remain unpaid after 90 days will be referred to a third party for collections.
* Please note that a $25 returned check fee will be added to the balance for all unpaid checks.

A misunderstanding can be an obstacle in establishing a successful relationship. If at any time you have a question regarding treatment, fee or service, please discuss it with us promptly and openly.

I, the undersigned, have read and understood the above and I consent to all the terms and conditions set forth in this agreement.

Signature_____ Date_____

Thank you for your cooperation and welcome to our practice!

Notice of Privacy Practices 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 have 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.

Name of Patient: _____ Date: _____

Signature: _____

Other Individuals Allowed Access To My Records:

Spouse_____

Mother_____

Father_____

Son/Daughter_____

Significant Other_____

Other_____