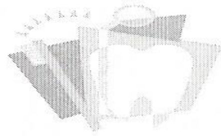


Welcome to High Street Dental, PC

Patient Information

Date ___________ Soc. Sec. # _________________________ Birthdate_________________

Name ____Home Phone _______________

Address____Cell Phone ________________

City __________________ State_____________________ Zip________E-mail ____________________

Sex M___ F___ Single______ Minor _____ Married _____Divorced_____ Widowed ______

Employer ____ Business Phone ______________

Business Address____Occupation_________________

Whom should we thank for referring you? ____

Emergency Contact ____

Primary Dental Insurance

Person responsible for account____

Relationship to patient______________________ Birthdate ___________ Soc. Sec. _________________

Address____Home Phone_______________

City _________________________________State ______________________ Zip___________________

Responsible party employed by __________________________________Business Phone ____________

Business Address____Occupation_________________

Insurance Company ___________________________________Address___________________________

Subscribers ID # _______________________________ Group #________________________________

Secondary Insurance

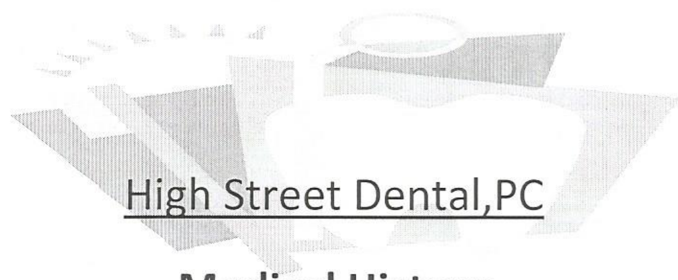
Insured Name____

Relationship to patient __________ Birthdate ______________ Soc. Sec. ________________________

Insurance Company __________________________________Address ___________________________

Subscribers ID ______________________________________ Group # __________________________

Patient/ Guardian Signature ____



High Street Dental,PC

Medical History

Patients Name____

Are you having any pain or discomfort at this time? Yes _____ No _____

Please list your Medical Doctor's information below:

Physicians' Name ______________________________Phone number__________________________

For Women Only : Are you pregnant Yes_____ No_____ If yes, what month? ___________________

Are you currently nursing? Yes____ No____ Are you currently taking birth control pills? Yes ____ No_____

Have you ever had:	Yes	No
Heart Murmur		
High Blood Pressure		
Mitral Valve Prolapse		
Heart Surgery		
Rheumatic Fever		
Stroke		
Artificial Joints		
Diabetes		
Tuberculosis		
Asthma		
A.I.D.S.		
HIV Positive		
Chemotherapy		
Hepatitis A,B or C		
Anemia		

ALLERGIES:

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CURRENT MEDICATIONS

____
____
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____
____
____

List any serious medical condition(s) treated:

____

Consent: I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

The undersigned authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aid deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

1. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.

Patient/ Responsible Party Signature ____________________________________ Date_______________

High Street Dental, PC

Dr. Marvin Cohen, Dr. Michael Agabegi, Dr. Patrick Petrillo & Dr. Daniel DeRosa

We at High Street Dental, PC are proud to deliver the finest and most comprehensive dental care services today. In order to assist you with your health care investment, we are providing the following payment options:

A. Insurance:

We will be glad to process your insurance claim. In order to do so we request authorization to release any information including diagnosis and the records of any treatment or examination rendered to you or your child, to a third party payers and or other health care practitioners.

We also request authorization for insurance carriers to pay directly to our dental office. **The estimated amount not covered by your insurance is due at the time of treatment and may be paid by any one of the options listed below. Our estimates are subject to final approval by your insurance company, and therefore, the amount due to our office is subject to change.**

It is ultimately your responsibility to know your individual insurance coverage.

B. Initial Payment:

Our office requires a deposit of one half (1/2) at the start of treatment and payment in full once treatment is completed. There will be a 1.5 % finance charge with an annual rate of 18% that will be added to all outstanding accounts with balances over 90 days. A down payment is not required with Care Credit monthly payment plan.

C. Payment Options:

In the event your insurance does not cover your services at 100% or does not cover them at all, we will accept the following methods of payment: (Please check how you will be paying in this case):

1. ______Cash – includes money orders and personal checks. There will be a $25.00 charge for returned checks.
2. ______Charge Card – We accept Visa AND MasterCard, as payment for treatment to the extent your credit limit permits.
3. ______Care Credit – Offers a separate line of credit to cover your entire family's health care needs:
    - A credit line can be established and approval usually takes less than 10 minutes.
    - Care Credit has interest free options available.
    - There is no annual membership fee.
    - Monthly payments as low as 3% of the outstanding balance.

We will be happy to work with you to plan the most appropriate arrangements for your budget. Financing your treatment will allow you to begin treatment immediately and spread the cost over a period of time

We require that a 24 hour cancellation notice be given. Appointments that are missed without notice may be charged $25.00 per ½ hours missed appointment fee. After three (3) missed appointments without notification you may be asked to seek treatment elsewhere. There will be a $25.00 fee for duplication and forwarding of dental records. Additional fee for duplication of X-rays will be charged.

Patient/Parent if minor____ Date________________