

Welcome to Premier Periodontics, The Office of Dr. Sam J. Nechamkin ("Knee Sham Kin")

Date _____

Patient Information

Patient Name _____
Last First MI (Preferred Name)
Gender (M/F) _____ Marital Status _____ Birth Date _____ Social Security # _____
Driver's License # _____ E-Mail Address _____
Address _____
Street Apt # City State Zip
Phones #s Home _____ Work _____ Ext. _____ Best Time To Call _____
FAX _____ Pager _____ Other _____

Referral Information

Name of the Dental Office, Person, or Other Source that Referred You to Our Practice _____

Emergency Contact or Guardian Information

Name _____
Last First MI (Preferred Name)
Gender (M/F) _____ Marital Status _____ Birth Date _____ Social Security # _____
Driver's License # _____ E-Mail Address _____
Address _____
Street Apt # City State Zip
Phones #s Home _____ Work _____ Ext. _____ Best Time To Call _____
FAX _____ Pager _____ Other _____

Employment Information

Information is for The Patient The Guardian

Employer Name _____
Address _____
Street City State Zip Phone

Dental Insurance Information

Patient's Relationship to the Policy Holder Self Spouse Child Other
Policy Holder _____
Last First MI
Address _____
Street City State Zip Phone
Birth Date _____ Social Security # _____
Insurance Carrier _____
Address _____
Street City State Zip Phone
Policy Holder's Employer _____ Employer Phone # _____
Policy # _____ Group # _____

* We are happy to provide all necessary information for you to file to your secondary dental insurance carrier, if applicable.

Health History

Date of last dental visit? _____

Reason for this visit? _____

Have you ever had any complications following dental treatment? If yes, please explain:

Have you ever had previous periodontal treatment? If yes, when and for what reason:

Are you currently under the care of a physician(s)? If yes, please explain:

Name of Physician _____

Telephone Number _____

Name of Physician _____

Telephone Number _____

Are you currently taking any prescription or over-the-counter medications (please include vitamins)?

Do you use tobacco products?

Type: _____

How much? _____

How Long? _____

Have you ever had any of the following? Please check those that apply:

<input type="checkbox"/> AIDS / HIV	<input type="checkbox"/> Fainting	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Take Fish Oil
<input type="checkbox"/> Allergies	<input type="checkbox"/> Gastric Reflux Disease	<input type="checkbox"/> Mouth Ulcers	<input type="checkbox"/> Take Multi Vit / Vit E
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Growths	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tumors
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Currently Pregnant	<input type="checkbox"/> Egg Allergy
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Soy Allergy
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Codeine Allergy
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Restless Leg Syndrome	<input type="checkbox"/> Penicillin Allergy
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Sulpha Allergy
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> <i>List Other Drug Allergies:</i>
<input type="checkbox"/> Diverticulitis / IBS	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Sjogren's Syndrome	_____
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stomach Problems	_____
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> Take Baby Aspirin	_____

Do you have any health problems that need further clarification? If yes, please explain:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

Signature

Date

CONSENT FOR SERVICES

AUTHORIZATION FOR DENTAL EVALUATION, CONSULTATION AND TREATMENT

I authorize Sam J. Nechamkin, D.D.S., M.S. to administer evaluation, consultation and treatment, if I choose, for a dental related condition that I possess. I understand that I will be instructed about my condition, the recommended treatment, and the reasons why it is considered necessary. Additionally, I understand that I will be informed of its possible complications, advantages, and its alternatives. As in any medical / dental treatment, I understand that there are unknown risks as well as known risks. Further, I understand that the above matters and any questions, which I pose, will be discussed with Dr. Nechamkin during consultation, before I accept any dental treatment. Lastly, I have been informed that if I accept treatment, I may be asked to sign additional consent forms for such procedures as intravenous sedation and dental implants.

RELEASE OF INFORMATION

I hereby request and authorize Sam J. Nechamkin, D.D.S., M.S. and his authorized staff to release information relevant to my dental condition to any insurance company or professional facility which may be involved in my care. I also authorize Dr. Nechamkin and his authorized staff to review my medical history, prescription formulations, and insurance information for the purpose of providing dental treatment. In many cases additional diagnostic services will be necessary for optimum prognosis and/or treatment, i.e.: CAT scan via iCAT. If I require a CD/DVD or other electronic media of the CAT scan and/or diagnostic interpretation for purposes other than treatment in Dr. Nechamkin's office, I understand that preparation and interpretation is required outside of a normal working day and therefore is subject to additional fees. Exact fee is dependant on the extent of my request but will range between \$25 and \$355. I agree to pay the requested fee prior to obtaining the records.

FINANCIAL RESPONSIBILITY

I understand that my insurance benefits are a contract between my insurance company and me. Thus, I understand that Dr. Nechamkin's office will assist me in filing insurance claims for any dental treatment and will follow my unpaid claims until a determination is made by my dental insurance carrier. Further, I understand that Dr. Nechamkin requires payment in full at least 1 week prior to a surgical appointment and payment in full at the time services are rendered for all other evaluations, hygiene services, or other dental services rendered by me. Consequently, I understand that because I have paid in full for services rendered, Dr. Nechamkin's office will request that payments from my insurance carrier be made directly to me.

ASSIGNMENT OF BENEFITS

I understand that if for whatever extreme circumstance that I have not paid in full for services rendered that I hereby assign to Sam J. Nechamkin, D.D.S., M.S. all insurance benefits and payments to which I am entitled from whatever source for any services, materials, and supplies which are furnished to me in conjunction with my dental treatment. I authorize Dr. Nechamkin and his authorized staff to seek such benefits and payments on my behalf. It is understood that Dr. Nechamkin's office will bill my insurance company directly for any dental treatment and that my assignment of benefits is ongoing and continuous unless and until canceled by me in writing to my insurance company with a copy to Dr. Nechamkin's office.

UNPAID INVOICES

Any invoice remaining outstanding and unpaid beyond sixty (60) days, without prior arrangements for payment, could result in outside collection activity. I agree to pay all costs and expenses of collection, including reasonable attorney's fees and court costs incurred by Sam J. Nechamkin, D.D.S., M.S. in the event that any unpaid invoices are referred to an outside agency or an attorney for collection.

CANCELTION / NO SHOW OF SURGERY AND/OR HYGIENE APPOINTMENTS

I understand that when I make a surgery and/or hygiene appointment that the doctor and/or hygienist has reserved an appropriate time specifically for my procedure. And, I understand that equipment and/or products might be purchased specifically for my procedure. Thus, unless I have undergone a *serious emergency*, I will give at least forty-eight (48) business hours notice prior to schedule changes. If I do not notify a member of Dr. Nechamkin's staff within 48 hours of my scheduled appointment, I agree to pay the assessed \$45 fee upon receipt of the invoice.

I have read and understand the above terms and conditions and agree to be bound thereby.

Signature of Patient or Guardian

Date

2/1/2008

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.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

