GOLD COAST smiles PLLC
Dr. Andrew Sami
128 Glen Street
Glen Cove, NY 11542
516-676-0250

Name: _____ _____ _____ Male Female
Last First MI

Title: Dr. Mr. Mrs. Ms. How do you wish to be addressed: _____

Address: _____
Mailing Address City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Date of Birth: _____ Social Security: _____ Employer: _____

Who may we thank for referring you to our practice? _____

DENTAL INSURANCE INFORATION

Employee/Subscriber Name:_____
Last First MI

Date of Birth: _____ Subscriber ID#: _____

Group/Employer: _____ Group Number: _____

Insurance Company Name: _____

Claim Mailing Address: _____

_____

Telephone Number: _____

I authorize release of any information concerning my/my child's health care recommendations and treatment for the purpose of evaluation and administering claims for insurance benefits.

I authorize payment of insurance benefits directly to Gold Coast Smiles.

I understand that my dental insurance benefits may be less than the fees for dental services and may not pay the fee charged in full.

I understand that I am responsible for and agree to pay the total fees for my/my child's dental treatment.

I agree tp pay any applicable deductible and estimated copayments on the date the dental services are rendered. I understand that not all dental treatment received may not be covered by my insurance plan and I agree to pay for any non-covered services on the date the dental services are rendered.

I agree to pay the total cost of dental services rendered on the date of services if I/my child does not have dental insurance benefits.

Patient/Guardian Signature: _____Date:_____

MEDICAL QUESTIONNAIRE

Patient Name _____ **Date Today** _____

Please check if you have any of the following problems:

- AIDS/HIV Positive
- Alcoholism
- Allergies

Describe _____
_____

- Anemia
- Arthritis
- Artificial heart valves
- Artificial joints
- Asthma
- Back problems
- Blood disease
- Cancer
- Chemotherapy
- Circulation problems
- Cortisone treatments
- Cough, persistent
- Cough, up blood
- Diabetes
- Epilepsy
- Fainting
- Food Allergies
- Glaucoma
- Headaches, migraines
- Eating Disorder
- Heart murmur
- Heart, any problems

Describe_____
_____

- Hemophilia
- Herpes
- Hepatitis A B C
- High blood pressure
- Jaw pains
- Kidney disease
- Liver disease
- Mitral valve prolapse
- Nervous problems
- Pacemaker
- Psychiatric care
- Radiation Treatment
- Respiratory disease
- Rheumatic fever
- Seizure disorders
- Shingles
- Shortness of breath
- Skin rash
- Stroke
- Surgical implants
- Swelling, feet or ankles
- Thyroid problems
- Tobacco use
- Tuberculosis
- Ulcers/colitis

Known Allergies:

- Local anesthetic
- Aspirin
- Penicillin
- Codeine
- Sulfa
- Iodine
- Latex
- Other: _____

List any medications you are currently taking:

_____
_____
_____
_____

Pre- medication required ____
Consulting Physician _____
Pharmacy_____

Check if you have had any problems with the following:

- Bad Breath
- Bleeding, sensitive gums
- Clicking or popping jaw: right or left
- Food trapping between gums
- Grinding or clenching teeth
- Loose teeth
- Broken fillings
- Periodontal treatment
- Sensitivity to cold
- Sensitivity to hot
- Sensitivity to sweets
- Sensitivity to biting
- Sores in mouth
- Staining

Authorization:

I have reviewed the information and answered all questions to the best of my knowledge. I understand this information will be used to determine the dental treatment I received at this office and may be shared with other medical offices as necessary. I will notify the office should any information change in the future.

Signature of patient, or parent if a minor: _____

Reviewed by: _____

Financial Agreement
Gold Coast Smiles

Gold Coast Smiles is committed to providing you with the best dental care available. Our philosophy in serving people is to be informative, honest and forthright. We have found that a clear understanding of our office financial polies relieves some of the anxiety associated with going to the dentist. We want to be certain that our policies are clear and that all of your questions are answered to your satisfaction. If you have any questions or concerns about our financial Agreement please do not hesitate to ask our office staff.

Payment Options

Payment is due at the time treatment is rendered. We accept Cash, Check, Master Card, American Express, Visa, and Discover.

As a service to our patients, we also offer no interest financing through CareCredit. With this option you can finance 100% of your dental care at no interest for 12 months with no upfront cost, no annual fees and no pre-payment penalties. You can begin your treatment today and conveniently pay with low monthly payments.

Dental Insurance

We are preferred Cigna PPO and Delta Dental PPO provider. In addition, we work with all dental insurance plans as a courtesy to our patients but you are responsible for our fees and not what your insurance company allows or considers ”usual, customary and reasonable,” all of which carry from one company to another.

We will make a Good Faith estimate for planned treatment but nit responsible for the accuracy of your insurance benefits (there may be a difference between the estimated portion and actual payment). As a service to you we will complete and file the appropriate forms with your insurance carrier(s). We are happy to provide any x-ray or additional information they may require in order to help maximize your benefits.

After dental insurance has paid their portion, a statement is sent to your mailing address on record for the remaining balance. Payment in full is expected within 30 days of the statement date. If your insurance denies your claim coverage or delays payments beyond 60 days from the claimed filed date, the entire amount will become due and payable by you. Although we make every effort to help you obtain your full benefit there are many variables we cannot anticipate.

Over Due Balances & Returned Checks

An account with an unpaid balance past 90 days will be sent to collection agency. At that time, you will be responsible for any and all cost incurred in the collection of your debt including finance charges applicable to your outstanding balance. Additionally, a $35 charge applies when a check is returned by the bank.

Broken or Missed Appointments

Your appointment is specifically reserved for you. Broken appointments prevent others from receiving the dental care they deserve. We take them seriously so please be considerate and inform us in advance if you need to change your appointment. Kindly give us 48 business hour notices if you need to make changes to your appointment. There is a $25 cancellation fee for every 10 minutes you were scheduled if we don't receive sufficient notice of 48 hours prior to your cancellation. In addition, patients who do not show up for Saturday appointments will not be given another Saturday appointment in the future.

Consent and Authorization:

I authorize payment to be made directly to Gold Coast Smiles DDS PLLC by my insurance company and I accept financial responsibility for all services not covered by my insurance. I authorized release of any medical care information requested by my insurance carrier. I hereby agree that in the event of default of any amount due and it this account is placed with a collection agency or attorney for collection or legal action, to pay additional charge equal to the cost of collection including any attorney or collection agency fees, applicable finance charges and court costs incurred and permitted by laws governing these transactions.

Signature_____ **Date** _____

GOLD COAST smiles PLLC
Andrew Sami, D.D.S
128 Glen Street
Glen Cove, NY 11542
516-676-0250

PATIENT CONSENT FORM
(HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out.

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this ____ day of _____, 20

Print Patient Name: _____

Relationship to patient: _____

Signature: _____

GOLD COAST smiles PLLC
Dr. Andrew Sami
128 Glen Street
Glen Cove, NY 11542
516-676-0250

Consent for Internet Communications

I grant my permission to Dr. Andrew Sami, DDS, and/or such associates or assistants to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured website for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Patient Name: _____

Signature: _____ Date: _____
(Patient, legal guardian or authorized agent of patient)

Relationship to Patient: _____