NEW YORK ORAL &
MAXILLOFACIAL SURGERY
DENTAL IMPLANT CENTER

MARK STEIN, DDS, MD
DAVID KOSLOVSKY, DDS, FACS

55 East 59th Street, 11th Floor, Suite 11, New York, NY 10022

Welcome!

Welcome to New York Oral & Maxillofacial Surgery! As a new patient at our practice, we kindly ask that you fill out the forms below by following these instructions.

If you are not able to complete the forms before your visit, please arrive 15 minutes early to your appointment to allow time to fill out the forms in our office.

Option 1: Fill Out Forms On Your Device & Email

1. Download the forms to your device.
2. Fill out the required fields and save the document.
3. Email the forms to renee@nyoralsurg.com, grace@nyoralsurg.com, or anel@nyoralsurg.com.

Option 2: Fill Out Forms By Hand & Bring Them To The Office

1. Print the forms.
2. Fill out the forms by hand.
3. Bring them to the office when you come for your appointment.

Option 3: Fill Out Forms On Your Device & Bring Them To The Office

1. Download the forms to your device.
2. Fill out the forms.
3. Save and print the forms.
4. Bring them to the office when you come for your appointment.

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PATIENT INFORMATION

Welcome to our office. So that we may assist you in filing your health insurance forms, please provide us with the information requested below. **PLEASE PROVIDE A COPY OF YOUR DENTAL & MEDICAL INSURANCE CARD.** All information is kept confidential.

Patient's Name: _____ Today's Date: _____

Sex: (Circle) ◯M ◯F Age: _____ Birth Date: _____ Soc. Sec: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Spouse's Name: _____

Responsible Party's Name: _____ Birth Date: _____

Soc. Sec: _____ Relationship to Insured: _____

Address: _____

Employer: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____

Name of Dental Insurance Plan: _____ Group Number: _____

Address of Dental Insurance: _____

Physician: _____ Referring Dentist: _____

Orthodontist: _____

Reason for Visit: _____

_____

Family members who have been patients here: _____

Preferred Pharmacy Name and Address: _____

_____

HEALTH HISTORY

Patient's Name: _____ Today's Date: _____

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1) Are you in good health?..... Y N

2) Has there been any change in your general health in the past year?..... Y N

3) Date of last physical exam: _____

4) Are you now under a physician's care for a particular problem?..... Y N

5) Have you ever had any serious illness?..... Y N

6) Height: _____ Weight: _____

7) **DO YOU HAVE OR HAVE YOU EVER HAD:**

A) Rheumatic Fever or Rheumatic Heart Disease?..... Y N
B) Congenital Heart Disease?..... Y N
C) Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)?..... Y N
D) Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)?..... Y N
E) Seizures, Convulsions, Epilepsy, Fainting, Dizziness, Psychiatric Treatment, or other Nervous Disorder?..... Y N
F) Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion, Do you bruise easily?..... Y N
G) Liver Disease (Jaundice, Hepatitis)?..... Y N
H) Kidney Disease?..... Y N
I) Diabetes?..... Y N
J) Thyroid Disease (Goiter)?..... Y N
K) Arthritis?..... Y N
L) Stomach Ulcers or Colitis?..... Y N
M) Glaucoma?..... Y N
N) Implants placed anywhere in your body?..... Y N
O) Radiation (X-ray) treatment for Cancer?..... Y N
P) Clicking or popping out of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?..... Y N
Q)Sinus or Nasal problems?..... Y N
R) Any disease, drug, or transplant operation that has depressed your immune system?..... Y N
S)HIV, AIDS, or ARC?..... Y N

8) **ARE YOU USING ANY OF THE FOLLOWING:**

A) Antibiotics?..... Y N
B) Anticoagulants (Blood Thinners)?..... Y N
C) Aspirin or drugs such as Motrin, Aleve, Ibuprofen?..... Y N
D) High Blood Pressure medications?..... Y N
E) Steroids (Cortisone, etc.)?..... Y N
F) Tranquilizers?..... Y N
G) Insulin or Oral Anti-Diabetic drugs?..... Y N
H) Digitalis, Inderal, Nitroglycerin,or other heart drug?..... Y N
I) Any regular prescription medicine, pills, or drugs?..... Y N
if YES, please list _____
J) Herbal or Holistic remedies, Vitamins or over-the-counter medications?..... Y N
if YES, please list _____
K) Oral or IV Bisphosphonates (Fosomax, Aredia, Zometa, Prolia, Reclast, etc.)?..... Y N

9) **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**

A) Local Anesthesia (Novacain, etc.)?..... Y N
B) Penicilin or other antibiotics?..... Y N
C) Sedatives, Barbiturates?..... Y N
D) Aspirin or Ibuprofen?..... Y N
E) Codeine or other pain killers?..... Y N
F) Latex or Rubber Products?..... Y N
G) Other allergies or reactions?..... Y N
if YES, please list _____

10) Do you smoke or chew tobacco?..... Y N
11) Do you vape?..... Y N
12) Do you use cannabis (marijuana) in any form, including edibles?..... Y N

13) Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide?..... Y N

14) Have you had any serious problems associated with any previous dental treatment?..... Y N

15) Have you or an immediate family member had any problem associated with intravenous anesthesia?..... Y N

16) Do you have any other disease, condition, or problem not listed above that you think the doctor should know about?..... Y N

17) Do you wish to talk to the doctor privately about anything?..... Y N

18) **FEMALES ONLY:**

A) Are you pregnant, or is there any chance you might be pregnant?..... Y N
B) Are you nursing?..... Y N
C) **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

Date: _____ Signature: _____ Doctor's Initials: _____

Medical Update: I have read my Health History dated: _____ and confirm that it adequately states past and present.

Date: _____ Exceptions: _____ Signature: _____ Doctor's Initials: _____

TEL: 212.888.4760 FAX: 212.888.4710

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CURRENT MEDICATIONS

In order for Dr. Stein and Dr. Koslovsky to render safe and proper treatment, our office has to be informed of all the medications you are currently taking.

Please list all the current medications you are taking below. This must include all prescriptions, over the counter medications, vitamins, and herbal supplements.

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ALLERGIES & PHARMACY INFORMATION

Date: _____

Patient Name: _____

Are you Allergic to Penicillin? (circle one): **Yes** **No**
Do you expect RX to be delivered? (circle one): **Yes** **No**

Any other Allergies? _____

If patient has list of medications: Can patient take their medications the day of appointment? (circle one): **Yes No OR Special Instructions:** _____

_____

Patient Pharmacy
Name: _____
Full Address: _____
Telephone #: _____

Office Staff: Scripts/RX Submitted to Pharmacy

Pt notified to pick up RX

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DENTAL INSURANCE INFORMATION

Name of Insurance Company: _____

Policy Holder's Name: _____ Patient Holder SS#: _____

Policy Holder's Date of Birth: _____ Policy Group #: _____

Policy Holder's Employer: _____

The following must be signed in order for this office to release information to your dental insurance company regarding your treatment and claim.

I authorize the release of any information to the insurance company relating to my claim.

Patient Signature: _____ Date: _____
(or legal guardian if minor)

Please be advised that Dr. Mark Stein does not participate with ANY medical insurance plans.
You will be given an itemized receipt that can be used for your medical insurance claims.

ASSIGNMENT OF BENEFITS GUARANTEED TO COOPERATE

I authorize, Assign and direct payment of health insurance benefits to the office of Dr. Mark Stein, New York Oral & Maxillofacial Surgery, PC for monies due on bill which relate to services rendered. I understand that neither pre-authorization nor predetermination of benefits guarantees payment. I assign to the above medical/dental office the right to prosecute claims against the health insurance carrier who affords benefits, and I agree to fully cooperate with this medical/dental provider's efforts to prosecute a claim against health insurance carrier, if there is no timely payment of this claim.

Patient Signature: _____ Date: _____
(or legal guardian if minor)

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NOTICE OF PRIVACY PRACTICES - PATIENT ACKNOWLEDGEMENT

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practices's legal duties with respect to my protected healh information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information
- A statement that this practice is required to abide by the terms of the notice currently in effect
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization
- A description of uses and disclosures that are prohibited or materially limited by law
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization
- My indivudual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to the practice and to the Secretary of HHS if I believe my privacy rights have been violated. and that no retaliatory actions will be used against me in the event of such a complaint
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction
    - The right to receive confidential communications of protected health information
    - The right to inspect and copy protected health information
    - The right to amend protected health information
    - The right to receive an accounting of disclosures of protected health information
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Patient Signature: _____ Date: _____

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CANCELLATION POLICY

Dr. Stein, Dr. Koslovsky, and our staff pride themselves on providing the utmost care possible to all patients. We understand that your time is valuable - we ask that you recognize that ours is as well. As there are many patients who seek to have surgery, our schedules are completed many weeks/months in advance, and it is difficult to fill a last-minute cancellation. In light of this, please call our office at least 48 hours in advance if you are unable to keep your scheduled appointment.

Should an appointment be cancelled within 48 hours (or if there is a no-show), any pre-paid deposit will be forfeited. Any exception to this policy will be made at the individual discretion of Dr. Stein and Dr. Koslovsky. Immediate rescheduling of a cancelled or missed appointment is greatly appreciated. However , the office reserves the right to not re-appoint an individual with repeat cancellation and/or missed appointments unless approved directly by Dr. Stein and Dr. Koslovsky.

Patient's Name: _____

Today's Date: _____

APPOINTMENT INSTRUCTIONS

PLEASE BE ADVISED! IT IS YOUR patient responsibility to remember the following once you schedule your treatment appointment:

Have NOTHING to EAT or DRINK, NO FOODS OR LIQUIDS- This means NO WATER, NO COFFEE, NO FOODS 6 HOURS prior to your scheduled treatment/appointment time!

You will not recieve treatment if these instructions are NOT followed.

Please be sure to arrange someone to pick you up/take you home and have them be present 10 minutes before you are dismissed.

If you do not have anyone to pick you up, we ask you take car service/Uber home. No public transporation please.

These instructions are for your own safety.

MEDICATIONS: Upon scheduling your treatment/surgery appointment our clinical department will generate prescriptions to the pharmacy you provided to be E-filed. Your doctor is the only one who can authorize any prescriptions. Once your pharmacy notifies you that they are ready for pick up, we urge you to please go and pick them up. With narcotic/pain medications, the pharmacies will return and delete the prescription if it is not picked up within 24 hours of them notifying you.

Thank you.

Patient's Name: _____ Today's Date: _____