NEW YORK ORAL &
MAXILLOFACIAL SURGERY
DENTAL IMPLANT CENTER

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

800B Fifth Avenue Suite 1 NEW YORK, NEW YORK 10065

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: ______________________________

City: ______________________ State: __________ Zip: __________

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) Aspirinor 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) Digitals, 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, 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) Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide?..Y N

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

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

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

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

16) **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 understad 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 ready my Health History dated: ____________ and confirm that it adequately states past and present

Date: ______________ Exceptions: ______________ Signature: ______________ Doctor's Initials: __________

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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 medication you are currently taking

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

____

____

____

____

____

____

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COVID-19 POLICY

Please email or bring with you a copy of your vaccination card or screenshot of your NYS Vaccination Active Pass from your Phone APP for all individuals attending the appointment.

Masks are required inside the office until you're asked to remove it by the doctors.

Thank you

TEL: 212.888.4760 FAX: 212.888.4710 WWW.NYORALSURG.COM

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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 Holders 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 Yor 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 permited 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. Our time is very valuable, and we understand yours is as well. As there are many patients who seek to have surgery, Dr. Stein and Dr. Koslovsky's schedule is completed many weeks/months ahead, and it is very 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.

It is our office policy not to reschedule any appointment that has been cancelled twice before. All future appointments will be made at Dr. Stein's and Dr. Koslovsky's discretion.

If you cancel your appointment without providing our office 48 hours notice, you will be charged a fee of $250.

Patient's Name: ______________________

Today's Date: ______________________

TEL: 212.888.4760 FAX: 212.888.4710 WWW.NYORALSURG.COM

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: ____________________