Les Belles NYC
THE DAWN OF YOUR NEW SMILE

212-804-8884
LesBellesNYC@gmail.com
www.lesbellesnyc.com

420 Lexington Ave Suite 228
New York, NY 10170

PATIENT FORM AND HEALTH HISTORY

Welcome to Les Belles NYC. Please complete, e-sign and submit these forms or bring them with you to your appointment.
Please feel free to call us at **212-804-8884** if you have questions.

PATIENT INFORMATION

Date (MM/DD/YR)____________________

Name (LAST, FIRST, MIDDLE INITIAL)____ Social Security #____________________________________

Preferred Name____

❑ Male ❑ Female Birthdate (MM/DD/YR)______________ ❑ Married ❑ Single ❑ Minor ❑ Partnered for_____years

Address (STREET, CITY, STATE, ZIP)____

Email Address ____

Home Phone #__________________________ Cell Phone #___________________________ Work # _________________________

Occupation____

Employer/School____

Who may we thank for referring you?____

In case of emergency, who should be notified? Name_ ___________________________ Phone_________________________

PRIMARY INSURANCE

Name of Subscriber (LAST, FIRST, MIDDLE INITIAL)____

Relation to Patient: ❑ Self______________________ ❑Other_____________ Birthdate (MM/DD/YR)_______________

Insurance Company Name__________________________________ Insurance Company's Phone #____________________________________

Subscriber ID #____ Group #____

Do you have a secondary dental insurance? ____

INSURANCE AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance coverage with ____
(name of insurance carrier(s)) and assign directly to Les Belles NYC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Les Belles NYC may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature (Patient, Parent, Guardian or Personal Representative) ______________________________

Relationship to patient ______________________________

Date (MM/DD/YR) ______________________________

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DENTAL HISTORY

Reason for today's visit ______________________________

Date of last dental care ______________________________

Former Dentist (NAME, PHONE, CITY, STATE) ______________________________

Check if you have problems with the following:

- ❑ Bad Breath
- ❑ Food Collection Between Teeth
- ❑ Periodontal Treatment
- ❑ Sensitivity to Sweets
- ❑ Bleeding Gums
- ❑ Grinding Teeth
- ❑ Sensitivity to Cold
- ❑ Sensitivity When Biting
- ❑ Clicking or Popping Jaw
- ❑ Loose Tooth or Broken Fillings
- ❑ Sensitivity to Hot
- ❑ Sores or Growths in Your Mouth

How often do you floss?______________________ How often do you brush?______________________

On a scale of 1-10 (1 being poor/10 being excellent), how would you rate your smile?________

If you could change one thing about your smile, what would it be?______________________________

MEDICAL HISTORY

Physician's Name______________________________ Date of last visit ______________________

Have you ever taken any of the group of drugs collectively referred to as "FEN-PHEN?" These include combinations of Ionimin, Adipex,Fastin (phen-termine), Pondimin (fenfluramine) and Redux (dexfenfluramine) ❑ Yes ❑ No

Have you had any serious illnesses or operations? ❑ Yes ❑ No -If yes, describe______________________________

Have you ever had a blood transfusion? ❑ Yes ❑ No -If yes, give approximate date(s) ______________________________

Are you receiving or have you ever received/taken INTRAVENOUS Bisphosphonates? ❑ Yes ❑ No

WOMEN:

Are you pregnant? ❑Yes ❑ No   Nursing? ❑ Yes ❑ No   Taking birth control pills? ❑ Yes ❑ No

Check if you have or have had any of the following:

- ❑ Anemia
- ❑Arthritis, Rheumatism
- ❑Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ HPV
- ❑ Chemotherapy
- ❑Circulatory Problems
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Cough Up Blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Skin Rash
- ❑Headaches
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Other ______________
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Tattoos/Piercings
- ❑ Pacemaker
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Sleep Apnea
- ❑Stroke
- ❑ Swelling of Feet or Ankles
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑Venereal Disease

MEDICATIONS

Please list any medications you are currently taking:______________________________

____

ALLERGIES ______________________________

Authorization: ❑I certify that the information I have provided is correct to the best of my ability

______________________________ Signature (Patient, Parent, Guardian or Personal Representative)

______________________ Relationship to patient

______________________ Date (MM/DD/YR)

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IF YOU NEED TO RESCHEDULE

Please be Conscientious with Your Appointments
• The doctor reserves each appointment just for you. We do not over book so please be on time.
If you must change your appointment please call 48 hours in advance..
• We will make every effort to contact you to confirm your appointment well in advance, however if you have not responded to confirm, we may need to give your appointment to another patient with a dental need.

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HIPAA POLICY

Les Belles NYC
Notice of Privacy Practices: Use and Disclosure of Health Information Protected under HIPAA
Effective October 1, 2015

This document provides a summary of how health care information about you may be used and disclosed and how you can obtain access to this information. We understand that information about you and your health is personal. We are committed to protecting your health information. It is our policy that the privacy of your protected health information (PHI) not be compromised while still allowing necessary access to assure that the health care you receive is appropriate and of the highest possible quality.

We pledge to you that we will protect the confidentiality of information provided to us. Your information will be used in the following manner, known as Treatment, Payment, and Healthcare Operations (TPO):

1. To provide dental treatment and/or services.
2. To facilitate payment by third party payers, when appropriate, for health care treatment you receive.
3. To facilitate the mechanisms which allow the operation of our facility.

In every use of your information, we will be responsible custodians of your PHI and adhere to the standards set forth in the legislation, which created these privacy practices. We recognize that all patients have the right to privacy in matters relating to their health, and we will not use your PHI for uses other than TPO related to health care without your express permission.

You have the following rights regarding the medical information we maintain about you:

1. Access, upon request, to information that may be used to make decisions about your care.
2. To request restrictions or limitations on the PHI we disclose about you for treatment, payment or health operations. While we are not required to agree to your request, if we do agree, we will comply with the restrictions unless the information is needed to provide emergency treatment.
3. To request that we amend the PHI we maintain about you if you believe that the information we have about you is incorrect or incomplete.
4. To request an accounting of disclosures we have made for uses other than our own.
5. To request confidential communications; i.e., that we communicate with you in a certain manner or at a certain location.
6. To receive a paper copy of this notice.

All members of our staff are committed to adhering to the conditions set forth in this notice of privacy practices. Any violation will be grounds for disciplinary action. We reserve the right to change this policy in the future; such changes will be available to all patients.

Authorized Disclosures: Les Belles NYC will not use or disclose your PHI without your prior authorization. You can later revoke that authorization in writing to allow any future use and disclosure. The authorization will be obtained from you by Les Belles NYC.

Should you believe that your privacy rights have been violated, you may file a complaint with this facility or with the State oversight department; all complaints must be submitted in writing. You will not be penalized for filing a complaint.

Les Belles NYC may disclose information regarding my treatment and financials to the following person(s):

____

Patient acknowledgment: I acknowledge receipt of this information regarding my right to PHI privacy

______________________________	______________________	______________________
Signature (Patient, Parent, Guardian or Personal Representative)	Relationship to patient	Date (MM/DD/Y