Wladimir Gedeon, DDS., P.C.

PATIENT INFORMATION CHART

Today's Date ________________

Please Print Clearly

Patient Name: (First) ______________________________ **(Last)** ______________________________________

Date of Birth__________ **Social Security #:** ___________________ **Drivers License #:** ___________________

Address: ____ **City:** _____________________ **State:**______ **Zip**__________

Home Phone #: ____________________ **Cell #:**_____________________ **Email address:**__________________________

Referring Dentist: _______________________________ **Referring Person's Name:** _______________________________

Name of Employer: ____ **Phone #:** ______________________________

PRIMARY DENTAL INSURANCE: **Insurance Company:** ____

ID #: __________________________________ **Group Name:**____________________________ **Group #:** ____________

Responsible Party: _____________________________________ **Relation to Patient:** ______________________________

Date of Birth: _______________ **Social Security #:** _________________________ **Work Phone #:** ____________________

SECONDARY/MEDICAL INSURANCE: **Insurance Company:** ____

ID #: __________________________________ **Group Name:**____________________________ **Group #:** ____________

Responsible Party: _____________________________________ **Relation to Patient:** ______________________________

Date of Birth: _______________ **Social Security #:** _________________________ **Work Phone #:** ____________________

Person to Contact (who does not live with you) in case of an emergency:

Name: ________________________________ **Phone #:** _________________________ **Relation** ___________________

Address: ____ **City:** _____________________ **State:**______ **Zip**__________

PAYMENT TERMS:

PLEASE remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance. To control billing costs, we request that payment be made at the time of service. The patient and or responsible party agrees to pay INTEREST at the rate of 1 1/2% per month and all costs of collection, including reasonable attorney fees, on all amounts due on accounts more than 30 days from the date of service. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I further hereby assign all dental benefits, to which I am entitled, including, private insurance and another health plan to: Wladimir Gedeon, DDS. Assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I further give permission to pull a credit report as needed should my account be turned over to an outside source for a collection effort. I understand that all procedures performed by the Doctor are medically necessary and waive any defense to the contrary. **If you pay with a major credit card you will be charged a 3% service fee.**

RESPONSIBLE PARTY SIGNATURE: ____________________________________ **DATE:** ___________________________

ORAL & MAXILLOFACIAL SURGERY

Wladimir Gedeon, DDS., P.C.

MEDICAL HISTORY - Medical Doctor's Name:____________________ **Phone Number:** ____________

Patient Name: (First) ____________________ **(Last)** ____________________

Date of Birth______________ **Social Security #:** ______________ **Drivers License #:** ____________

1. When was your last physical examination? __________ Where: ____________________
2. What is the name of the doctor who did the physical: ____________________ Phone: __________
3. Have you been a patient in the hospital during the past two years?... ☐ Yes ☐ No
   For What?____
4. If you are currently taking any medicines, please list ______________________________
5. If you have allergies, YES___ or NO____ please list ______________________________
6. Have you ever had any excessive bleeding requiring special treatment?.. ☐ Yes ☐ No

DO YOU CURRENTLY SUFFER FROM ANY OF THE FOLLOWING:

Are you pregnant? ☐ Yes ☐ No How many months? ____________________

☐ Yes ☐ No............ Heart Disease, Attack or Heart Surgery? What & When____________________
☐ Yes ☐ No............ Heart Murmur
☐ Yes ☐ No............ Heart Pacemaker
☐ Yes ☐ No..............Artificial Heart Valve:
☐ Yes ☐ No............ Angina Pectoris (Chest Pain)
☐ Yes ☐ No............ High Blood Pressure
☐ Yes ☐ No..............Sleep Disorder Please list condition____________________
☐ Yes ☐ No............ Rheumatic Fever
☐ Yes ☐ No............ Fainting or Dizzy Spells
☐ Yes ☐ No....... Anemia
☐ Yes ☐ No............ Removable Dental Appliance ____________________
☐ Yes ☐ No............ Hemophilia
☐ Yes ☐ No............ Emphysema
☐ Yes ☐ No............ Asthma: When did you have your last asthma attack: ____________________
☐ Yes ☐ No............ Tuberculosis
☐ Yes ☐ No............ Stroke: When ____________________
☐ Yes ☐ No............ Cancer or Leukemia: When and if **cancer** Where: ____________________
☐ Yes ☐ No............ Chemotherapy or Radiation Treatment: When will it end: ____________________
☐ Yes ☐ No............ Epilepsy or Seizures
☐ Yes ☐ No............ Arthritis: Where ____________________
☐ Yes ☐ No............ Diabetes
☐ Yes ☐ No............ Alcohol, Drug Abuse or Other____________________
☐ Yes ☐ No............ Thyroid Disease
☐ Yes ☐ No............ AIDS or Related condition (Please circle the condition): ____________________
☐ Yes ☐ No............ Liver Disease
☐ Yes ☐ No............ Hepatitis what type? ____________________
☐ Yes ☐ No............ Yellow Jaundice
☐ Yes ☐ No............ Kidney Trouble
☐ Yes ☐ No............ Artificial Joint Where: ____________________
☐ Yes ☐ No............ Psychiatric Treatment for What: ____________________
☐ Yes ☐ No............ Ulcers (where): ____________________
☐ Yes ☐ No .... Blood Transfusion

Please list any other medical condition not listed above ____________________

☐ Yes ☐ No............ Do you Smoke – ☐ Yes Cigars...☐ Yes Tobacco...☐ Yes Chewing Tobacco – How many Packs a day ______

Are you wearing Contact lenses..............☐ Yes ☐ No Who is taking you home today? ____________________

Are you having surgery today, if so, have you had anything to eat or drink within the last 6 hours? ....☐ Yes ☐ No

To the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment Without Fail.

____

Date **Signature of Patient, Parent or Guardian** **Print Name of Patient, Parent or Guardian:**

Wladimir Gedeon, DDS., P.C.

93 West Street Suite 5
(203) 744-1240
http://drgedeon.com/

Danbury, CT 06810
Fax (203) 730-1455
CTdentalimplantcenter@yahoo.com

PRIVACY PRACTICE

Our Notice of Privacy Practice provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

I give permission for Dr. Wladimir Gedeon and staff to speak with the following individual(s) about my case :

Name:________________________________ Relationship To Patient: ___________________ Phone Number: ________________

Name:________________________________ Relationship To Patient: ___________________ Phone Number: ________________

I give permission for Dr. Wladimir Gedeon and staff to speak to other medical professionals about treatment plans and medical inquiries.

[ ] Yes [ ] No

I give permission for Dr. Wladimir Gedeon and staff to leave detailed voice messages in regards to specific appointments and treatment information on the following phone numbers:

Phone Number: ________________________ [_]Home [_]Cell Phone Number: __________________________ [_]Home [_]Cell

Patient Rights – The Patient Understands that:

- You can refuse to have protected health information disclosed or used for treatment, payment or health care operations.
- The Patient has the opportunity to review this Notice
- The practice reserves the right to change the Notice Of Privacy Policies
- The Patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The practice may condition treatment upon the execution of this Consent

__________________________________ __________________________________
Print Name **Signature of Patient or Representative**

__________________________________ ______________________________
Date **Relationship To Patient**

__________________________________ __________________________________
Staff Witness Printed Name **Staff Witness Signature**