Welcome To Our Practice

Dr. Stephen Barsky
1145 19th St. NW Ste 512
Washington DC 20036

Date________________

PATIENT INFORMATION

Mr. Mrs. Ms. Dr. (circle one) First Name______________________M.I.________Last Name________________________
Address____City________________________State________
Zip code___________________________Birth Date_________________________________Age_______________
Soc. Sec.#______________________________E-Mail____
Home tel.(_____)__________________Cell Phone (____)________________Business Phone___________________
I am a New Patient________Returning Patient_______
Prev. Dentist________________Physician____________________REFERRED BY______________________________
In Case of Emergency please contact:________________________________Tel.(_____)___________________________

WHO WILL BE REPSONSIBLE FOR YOUR ACCOUNT? (Circle one) Self Spouse Father Mother Other

Name_____________________________Soc.Sec_______________________Tel. (____)______________________
Street____________________________City_______________________State______________________Zip________

SPOUSE OR OTHER RESPONSIBLE PARTY OTHER THAN ABOVE

Name____________________________Soc.Sec._______________________Tel (____)______________________
Street____________________________City_______________________State______________________Zip________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY DENTAL:____
Employer____________________________________Bus. Tel. (____)____________________ext________________
Bus. Address____
Group #_________________________Group Name__________________________InsuredParty___________________
Relation_____________________________DOB____________________
Address if not above____
Tel. if not above (____)______________________________Soc. Sec.____

SECONDARY INSURANCE COMPANY

Employer____________________________________Bus.Tel.(____)____________________ext___________________
Bus. Address____
Group #_________________________Group Name__________________________Insured Party___________________
Relation_____________________________DOB_______________________
Ins.Co Address____
Ins. Co. Tel (_____)___________________________________Soc. Sec____________________________________

DENTAL INFORMATION

Brief Description of why you are visiting with us____
____

Please circle the appropriate information:

Discomfort in the Jaw, clicking or popping	Gum disease	New Patient exam__________________
Gums red,swollen, bleeding	toothaches	Cleaning__________________________
Prolonged bleeding with extractions	bad breath	Other_____________________________
Teeth are sensitive to hot, cold, sweet	food catching	
Lost or broken fillings or teeth	broken crowns or veneers	
Teeth grinding or clenching	Difficulty in opening or closing jaw	

LAST DENTAL VISIT______________LAST DENTAL X-RAYS_________________HOW OFTEN DO YOU FLOSS________

COSMETIC EVALUATION

Circle one or more
Are your teeth crowded
Do you have large spaces
Are your teeth stained or discolored
Are your teeth crooked
Previous Orthodontics
Do you have large dark silver fillings
I would be interested in whitening my teeth
I would be interested in straightening my teeth
I would be interested in veneers
I would like to change my fillings
Other cosmetic concerns____

MEDICAL HISTORY

Circle each that apply
Rheumatic fever
Mitral valve prolapse
Heart murmur
High blood pressure
Low blood pressure
Chest pain/Angina
Heart attack
Pacemaker
Bronchitis/Chronic cough
Chronic fatigue
Mental health problems
Damaged heart valves

Asthma
Allergies
Sleep apnea
Respiratory problem
Tuberculosis
Emphysema
Do you smoke y___n____
Use any tobacco y___n___
Blood disorders
Use ofl controlled substances
Glaucoma
Abnormal bleeding
Immune system problems

Hepatitis
HIV
Jaundice
Fainting spells
Epilepsy
Stroke
Thyroid disease
Diabetes
STD's
Low blood sugar
Kidney disease
Radiation/Chemo

Other medical complications not mentioned____
____

MEDICATIONS

Please indicate which medications you are currently taking____
____
____

MEDICATION ALLEGIES

Are you allergic to or had a reaction to:
Penicillin
Asprin
Codeine
Local anesthetics
Latex
Amoxicillin
Other____

Female patients
Are you pregnant
Are you nursing
Are you taking birth control pills

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

X Signature of patient____**Date**___________________________
Parent or guardian

CANCELLATIONS/BROKEN APPOINTMENTS

It is our policy to be punctual and available to our patients. We ask that we be given at lease 24 hours notice is you cannot make an appointment. Failure to contact us will lead to a fee based on a per hour basis. Our patients understand that our expertise and time is what we offer to you.

FEES AND PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. We offer financing through several banks which may be interest free for up to a year. An estimate of the charge for any procedure will be given to you upon request. We will be pleased to aid you with your Dental insurance so that you can be properly reimbursed.
It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys fees and court costs.

X Signature of Patient (parent or Guardian) **X**______________________________________**Date**_________________________
This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this Doctor named of the benefits otherwise payable to me.

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given an opportunity to ask any questions I may have regarding this notice

X Signature of Patient (Parent orguardian)____**Date**__________________________

We would like to welcome you to our dental family. Our goal is to give you the best dentistry possible to keep your teeth healthy for the rest of your lifetime.

Dr. Stephen Barsky and Staff