Bensonhurst Smiles Registration Form

First Name: Last Name: Male / Female

Date of Birth: Social Security Number:

Street Address:

City: State: Zip Code:

Phone #: Email:

Your preferred way of contact: Phone Call / Text / Email

Employer:

Emergency Contact

Name: Relationship: Phone #:

Medical History

Do you have or have you had any of the following medical conditions or procedures?

Y N Heart Attack/ Stroke
Y N Cosmetic Surgery
Y N Shingles
Y N Liver Problems
Y N Rheumatic Fever
Y N Asthma
Y N Arthritis/Rheumatism
Y N Stomach Problems/Ulcers
Y N Heart Disease
Y N Leukemia
Y N Fainting/Seizures/Epilepsy
Y N Alcohol/Drug Abuse
Y N Scarlet Fever
Y N Bleeding Problems
Y N Back Problems
Y N Thyroid Problems
Y N Heart Surg./ Pacemaker
Y N Xray or Cobalt Treatment
Y N Hepatitis
Y N Respiratory Problems
Y N Mitral Valve Prolapse
Y N Difficulty Breathing
Y N Artificial Bones/Joints
Y N Psychiatric Problems
Y N Congenital Heart Defect
Y N Anemia
Y N Severe/Frequent Headache
Y N Tuberculosis TB
Y N Nervousness
Y N Glaucoma
Y N Cancer/ Tumors
Y N Kidney Problems
Y N Heart Murmur
Y N Chemotherapy
Y N HIV+/AIDS/ARC
Y N Sinus Problems
Y N Artificial Valves
Y N Diabetes/Hypoglycemia
Y N Emphysema
Y N Venereal Disease
Y N Chest Pains
Y N High/Low Blood Pressure
Y N Frequent Neck Pain
Y N Jaw Problems TMJ/TMD

Please list any other surgeries or medical conditions you have or ever had:

What medications are you taking:

Do you require Pre-medication?
Are you allergic to Latex, any antibiotics, or Anesthetics?
Any history of smoking? If yes, how much and how long?

For women:
Are you taking Birth Control pills?
Are you pregnant? If yes, how long?
Are you nursing?

Bensonhurst Smiles
Consent Information

CONSENT TO TREAT:

This information I have provided Dr. Chung Hin Lau's office is completed and true to the best of my knowledge

I authorize the doctors and staff of Chung Hin Lau, DDS., PLLC, to administer such procedures and treatment as they deem necessary

Patient or Legal Guardian Signature:____________________________________

Date:_______________________

CONSENT TO TREAT A MINOR CHILD:

The information i have provided this office pertaining to _____________________ is true and complete to the best of my knowledge

I authorize the doctors and staff of Chung Hin Lau, DDS, PLLC, to administer such procedures and treatment as they deem necessary to my child/ward in my legal custody.

Patient or Legal Guardian Signature:____________________________________

Date:_______________________

FOR WOMEN ONLY:

The doctor and staff of Chung Hin Lau, DDS, PLLC has advised me that x-rays can be hazardous to an unborn child

At this time and to the best of my knowledge, I am NOT pregnant. I consent to having x-rays taken

Patient or Legal Guardian Signature:_____________________________________

Date:_______________________

Bensonhurst Smiles
Financial Policy

PATIENTS PAYING PRIVATELY:

I understand that payment is due the day the dental services are rendered.
If I am undergoing treatment that will consist of a few visits, I understand that payment is due by the final visit of treatment unless other financial arrangements have been made.

Patient or Legal Guardian Signature:_____________________________________
Date:________________________

PARTICIPATING INSURANCE PATIENTS:

I authorize release of any dental or other information which is necessary to process any claims that are submitted on my behalf.
I understand that Chung Hin Lau, DDS has agreed to bill my participating insurance company for the treatments performed and that I am financially responsible for ANY and ALL amounts not otherwise paid by my insurance carrier including but not limited to yearly deductibles, coinsurances, non-covered services, and if my yearly maximum has been reached.
I also agree to forward immediately any insurance payments that I receive for these services.
I request that payment of authorized insurance benefits be made on my behalf to Chung Hin Lau, DDS.

Patient or Legal Guardian Signature:_____________________________________
Date:________________________

NON-PARTICIPATING INSURANCE PATIENTS:

I authorize release of any dental or other information which is necessary to process any claims that are submitted on my behalf.
I understand that I am responsible for the difference between Dr. Chung Hin Lau's fees and my insurance company's allowable amount because the office is NOT participating with my insurance. I will pay for services rendered and the office will submit a dental claim for my reimbursement.

Patient or Legal Guardian Signature:_____________________________________
Date:________________________