55 Old Nyack Turnpike
Suite 103
Nanuet, NY 10954

307 Boulevard
Hasbrouck Heights
NJ 07604

NAME & ADDRESS

PATIENT'S NAME DATE OF BIRTH

WHAT DO YOU PREFER TO BE CALLED?

IF PATIENT IS A MINOR, PARENT/GUARDIAN'S NAME

RESPONSIBLE PARTY NAME

ADDRESS

CITY STATE ZIP

OCCUPATION

EMPLOYER

CONTACT INFO

CELL PHONE

HOME PHONE

WORK PHONE

EMAIL ADDRESS

PREFERRED CONTACT METHOD (Circle one) CELL HOME WORK EMAIL

PRIMARY DENTAL INSURANCE

MEMBER'S NAME RELATION

MEMBER'S SOC SEC NO DATE OF BIRTH

EMPLOYER

INSURANCE COMPANY

INSURANCE COMPANY CLAIM ADDRESS

CITY STATE ZIP

ID NUMBER POLICY NUMBER GROUP NUMBER

1

About You

55 Old Nyack Turnpike
Suite 103
Nanuet, NY 10954

307 Boulevard
Hasbrouck Heights
NJ 07604

PERSONAL INFO

NAME

DATE OF BIRTH: GENDER: M F

OCCUPATION: MARITAL STATUS: S M D W

GENERAL HEALTH

GENERAL HEALTH	YES	NO	IDK
Do you have active tuberculosis, a cough persisting more than three weeks or a cough that produces blood? If yes, stop and notify the receptionist.	☐	☐	☐
Are you now under the care of a physician?	☐	☐	☐
Physician's name:			
Physician's address:			
Are you in good health?	☐	☐	☐
Has there been any change in your health within the past year? If yes, what condition:	☐	☐	☐
Have you had a serious illness, operation or have been hospitalized In the past 5 years?	☐	☐	☐
If yes, what was the illness?			

Date of your last physical exam:

List your medications:

RISK OF OSTEONECROSIS OF THE JAW

RISK OF OSTEONECROSIS OF THE JAW	YES	NO	IDK
Are you taking, ever took, or scheduled to take alendronate (Fosomax® or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated, or are you presently scheduled to begin treatment with the IV bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer?	☐	☐	☐

Date treatment began:

ANTIOBIOTIC PROPHYLAXIS

ANTIOBIOTIC PROPHYLAXIS	YES	NO	IDK
Have you had any joint replacement?	☐	☐	☐
Artificial heart valve?	☐	☐	☐
Previous infective endocarditis?	☐	☐	☐
Damaged valves in a transplanted heart?	☐	☐	☐
Congenital heart disease (CHD)?	☐	☐	☐
Unrepaired, cyanotic CHD?	☐	☐	☐
Repaired in last 6 months?	☐	☐	☐
Repaired CHD with residual defects?	☐	☐	☐
Has a physician or dentist ever told you to pre-medicate with antibiotics before dental treatment?	☐	☐	☐

Medical History

ALLERGIES	YES	NO	IDK
Local anesthetics	◻	◻	◻
Aspirin	◻	◻	◻
Penicillin or other antibiotics	◻	◻	◻
Barbiturates	◻	◻	◻
Sulfa drugs	◻	◻	◻
Codeine or other narcotics	◻	◻	◻
Metals	◻	◻	◻
Latex	◻	◻	◻
Iodine	◻	◻	◻
Hay fever or seasonal allergies	◻	◻	◻
Animals	◻	◻	◻
Food	◻	◻	◻
Other	◻	◻	◻

DISEASES	YES	NO	IDK
Cardiovascular	◻	◻	◻
Angina	◻	◻	◻
Chest pain upon exertion	◻	◻	◻
Arteriosclerosis	◻	◻	◻
Congestive heart failure	◻	◻	◻
Damaged heart valves	◻	◻	◻
Heart attack	◻	◻	◻
Heart murmur	◻	◻	◻
Low blood pressure	◻	◻	◻
High blood pressure	◻	◻	◻
Mitral valve prolapse	◻	◻	◻
Pacemaker	◻	◻	◻
Rheumatic fever	◻	◻	◻
Rheumatic heart disease	◻	◻	◻
Abnormal bleeding	◻	◻	◻
Anemia	◻	◻	◻
Blood transfusion If yes, date:	◻	◻	◻
Arthritis	◻	◻	◻
Autoimmune disease	◻	◻	◻
Rheumatoid arthritis	◻	◻	◻
Systemic lupus	◻	◻	◻
Asthma	◻	◻	◻
Bronchitis	◻	◻	◻
Emphysema	◻	◻	◻
Sinus trouble	◻	◻	◻
Cancer/Chemo/Radiation	◻	◻	◻

LIFE STYLE	YES	NO	IDK
Do you wear contact lenses?	◻	◻	◻
Do you use controlled substances or drugs?	◻	◻	◻
Do you use tobacco? (Smoking, snuff, chew, bidis)	◻	◻	◻
Do you drink alcoholic beverages? If yes, how much in the last 24 hours? If yes, how much in a typical week?	◻	◻	◻

WOMEN ONLY	YES	NO	IDK
Are you pregnant? If yes, number of weeks:	◻	◻	◻
Are you taking birth control pills?	◻	◻	◻
Are you nursing?	◻	◻	◻

	YES	NO	IDK
Chronic pain	◻	◻	◻
Diabetes (circle one) Type I, Insulin dependent Type II	◻	◻	◻
Eating disorder	◻	◻	◻
Malnutrition	◻	◻	◻
Gastrointestinal disease	◻	◻	◻
GE reflux	◻	◻	◻
Ulcers	◻	◻	◻
Thyroid problems	◻	◻	◻
Stroke	◻	◻	◻
Glaucoma	◻	◻	◻
Hepatitis, jaundice, liver disease	◻	◻	◻
Epilepsy	◻	◻	◻
Fainting or seizures	◻	◻	◻
Neurological disorder If yes, explain:	◻	◻	◻
Sleep disorder	◻	◻	◻
Recurrent infections	◻	◻	◻
Kidney trouble	◻	◻	◻
Night sweats	◻	◻	◻
Osteoporosis	◻	◻	◻
Persistent swollen glands	◻	◻	◻
Migraines	◻	◻	◻
Rapid weight loss	◻	◻	◻
Sexually transmitted disease	◻	◻	◻
Excessive urination	◻	◻	◻
Other	◻	◻	◻

Patient signature *Date*

Doctor's signature *Date*

Dr. Karen Bergonio
55 Old Nyack Tpke, Suite 103 | NANUET NY, 10954 | (845) 623-0710
307 Boulevard | HASBROUCK HEIGHTS NJ, 07604 | (201) 257-8452

Written Financial Policy

Thank you for choosing Dr. Karen Bergonio. Our primary mission is to deliver the best and the most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

-Cash, Check, Visa, Mastercard, American Express or Discover Card.

Or Convenient Monthly Payment Plans. *Subject to credit approval.* from CareCredit

- Allow you to pay over time
- No annual fees or pre-payment penalties
- Up to one year Interest Free

Please Note:

Dr. Karen Bergonio requires payment prior to completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

We accept payment in thirds for treatments over $1,000. For plans requiring more than 3 appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $2000 or more, a 50% deposit is required to secure your initial treatment appointment.

We also offer in-house financing for treatments over $1,000.00.

Any account with balances over 30 days and are without an established current payment plan will be sent to a collections agency. Your will be responsible for all fees charged by the collection agency

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. *However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.* **We will gladly process your claim but we request that you pay your estimated portion when services are rendered.**

A fee of $20.00 is charged for patients who miss or cancel more than 1 time in a calendar year without a 24 hour notice.

Dr. Karen Bergonio charges $30 for returned checks

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

____

Patient, Parent or Guardian Signature Date

____

Patient Name (Please Print)

PRIVACY POLICY ACKNOWLEDGMENT

I have received the Notice of Privacy Policy and I have been provided an opportunity to review it.

Name ____ Birthdate ________________

Signature ____ Date ____________________