Devin Joseph Okay, D.D.S. P.C.

REGISTRATION FORM

Section I: **Patient Information** **Date**_____

Name: I Prefer to be called: _____

Address: _____ City: _____ State: __ Zip _____

Phone (_____) _____ Work Phone (_____) Cell Phone (_____) _____

Email Address _____

The best time to contact me is: _____ ☐ A.M. ☐ P.M. On my ☐ Home phone ☐ Work phone ☐ Cell phone ☐ Email

Date of Birth: _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Whom may we thank for referring you? _____

Section II **Health History**

Are you now under the care of a physician: ☐ Yes ☐ No

If yes, please explain: _____

Name of physician: _____

Last physical was on: _____

Has there been any change in your general health within the past two years: ☐ Yes ☐ No

If yes, please explain: _____

Are you taking any medications (including Aspirin): ☐ Yes ☐ No

If yes, what kind: _____

Are you allergic or have you ever an unusual reaction to dental anesthetic, penicillin, aspirin, codeine, sulfa, barbiturates, other:

_____

Have you had/do you currently have any of the following:

Anemia ☐	Fainting ☐	Low Blood Pressure ☐
Arthritis ☐	Foreign Implants ☐	Mental disorders ☐
Artificial Joints ☐	Frequent headaches ☐	Mitral valves prolapse ☐
Asthma ☐	Glaucoma ☐	Nervous disorders ☐
Blood disease ☐	Growths ☐	Pacemaker ☐
Cancer ☐	Head injuries ☐	Pregnancy/due date_____
Chemotherapy ☐	Heart attack ☐	Radiation therapy ☐
Diabetes ☐	Heart disease ☐	Respiratory problems ☐
Dizziness ☐	Hepatitis ☐	Rheumatic fever ☐
Drug addiction ☐	High blood pressure ☐	Rheumatism ☐
Embolism ☐	Immune deficiency/HIV+ ☐	Stroke ☐
Excessive bleeding ☐	Liver disease ☐	Other_____

Dental History Cont.

Date of last dental visit: _____ Reason for this visit: _____

Is this visit due to any accident or injury: _____

Do your gums bleed: ☐ Yes ☐ No

Do you have sensitive teeth: ☐ Yes ☐ No

Are you troubled with bad breath: ☐ Yes ☐ No

Have you noticed any loosening of your teeth: ☐ Yes ☐ No

Are you happy with your smile: ☐ Yes ☐ No

If no, why: _____

CONTINUED ON OPPOSITE SIDE→

509 Madison Ave., Suite 2100, New York, NY 10022; Phone 212-750-0050; Fax 212-486-0012

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Section III **Privacy Policy**

Ok to disclose your health information to a physician or specialist providing treatment to you

Ok to leave messages regarding dental appointments I hereby authorize payment directly to this dental office and understanding that my dental insurance is an agreement between my insurance company and me. I understand that I am ultimately responsible for all charges incurred at this office regardless of insurance benefits.

Patient Signature_____

Doctor's Signature_____ Date Reviewed_____

Our Mission

In our dental practice, we strive to serve the needs of you, our valued patients, to the best of our ability. We aim to provide the highest quality dental care in a relaxed and comfortable environment. We understand that you have a choice in dental care, and we thank you for choosing our office.

Patient Agreements

Confirmation ***(Please Initial)***

_____ *It is imperative that you confirm your scheduled appointment with our office at least 2 business days prior to your appointment. Your appointment time is reserved for you. Confirming your appointment allows us to provide quality care and appointment times for all of our patients. You may reach us during office hours, leave a voicemail message after hours, or send an email to office@devinokay.com. If we have not heard from you, we will make every effort to contact you at the numbers you have provided us. Unconfirmed appointments are subject to cancellation.*

Arrival

_____ *We understand that your time is limited and valuable. We will make every effort to see you at your appointed time. For this reason, we ask you to be ready for treatment at your appointed time. We understand that unforeseen circumstances can cause delays in your arrival. In order to provide you with the necessary time to complete your treatment, we may ask that you reschedule any appointment that we cannot complete during your scheduled time.*

Minors

_____ *Children under the age of 18 must be accompanied by a parent or legal guardian for the first dental visit in our office. Future dental treatment will not be performed without prior arrangements between our office and a consenting adult. If a minor child arrives without arrangements for dental treatment, the appointment will be rescheduled.*

Length of Appointment

_____ *In order to serve you with our undivided attention, we schedule your dental treatment as a block of time. This allows us to focus only on you and assures you that you will be finished with your dental appointment on time. For any appointment longer than 60 minutes, we ask for one-half of your payment when the appointment is made and the second half at your scheduled appointment.*

Cancellations and Rescheduling

_____ *We understand that it may become necessary to change an appointment. As a courtesy to our staff and to our other patients, we ask that you let us know immediately if you cannot keep your appointment.*

Dental Insurance

_____ *As a professional courtesy, we will submit your dental insurance claims. While we will assist you in obtaining benefit information, we are not privileged with the detailed provisions of your particular plan. All estimates provided in our office are based on general benefit information. Questions regarding your specific dental benefits should be directed to your insurance company. You are ultimately responsible for all charges incurred in our office. You will receive a statement from our office for any unpaid balances.*

_____ _____

Patient Name / Parent or Legal Guardian *Date*

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