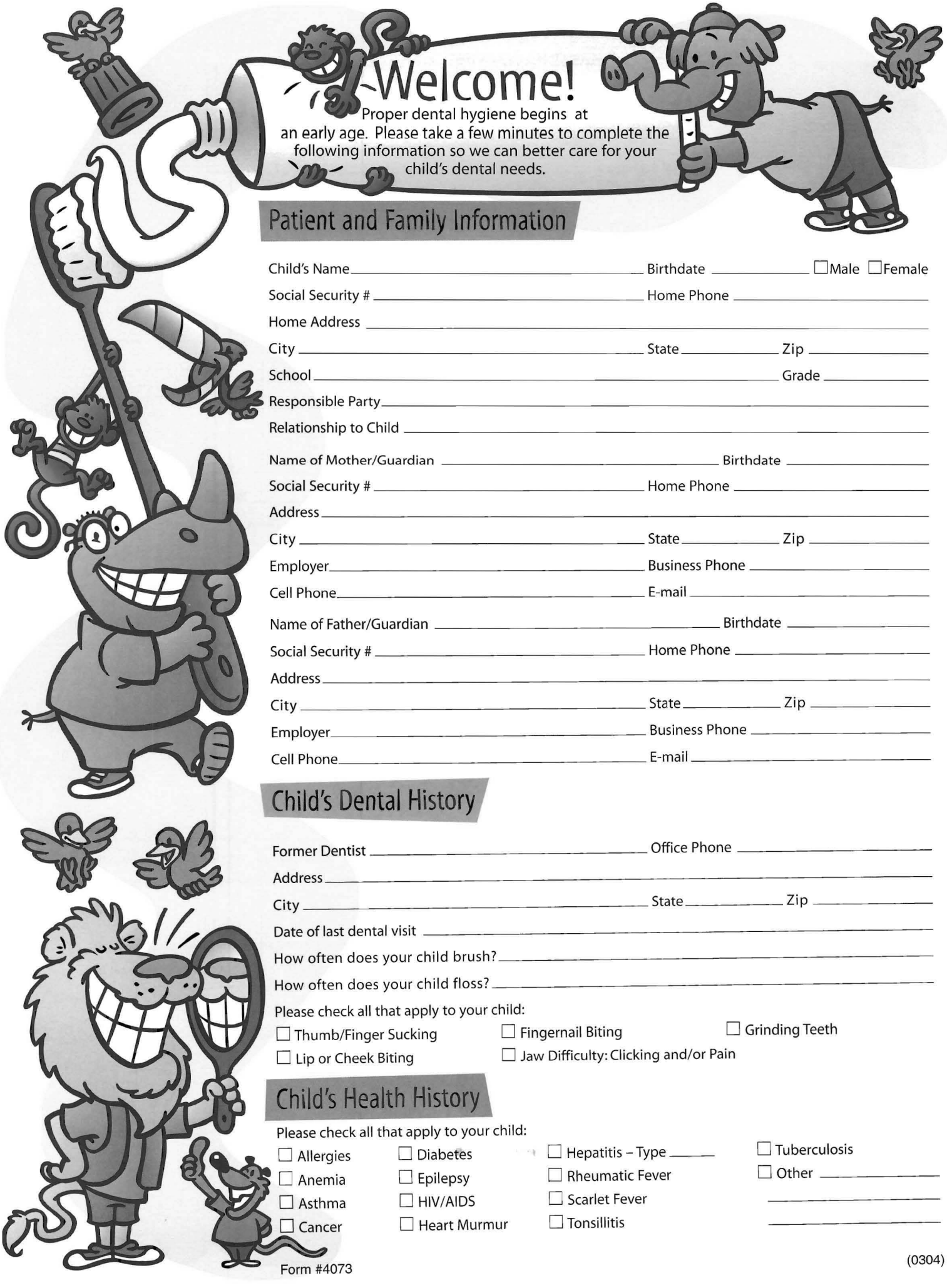


Welcome!

Proper dental hygiene begins at an early age. Please take a few minutes to complete the following information so we can better care for your child's dental needs.

Patient and Family Information

Child's Name _____ Birthdate _____ ☐Male ☐Female

Social Security # _____ Home Phone _____

Home Address _____

City _____ State _____ Zip _____

School _____ Grade _____

Responsible Party _____

Relationship to Child _____

Name of Mother/Guardian _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Cell Phone _____ E-mail _____

Name of Father/Guardian _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Cell Phone _____ E-mail _____

Child's Dental History

Former Dentist _____ Office Phone _____

Address _____

City _____ State _____ Zip _____

Date of last dental visit _____

How often does your child brush? _____

How often does your child floss? _____

Please check all that apply to your child:

☐ Thumb/Finger Sucking ☐ Fingernail Biting ☐ Grinding Teeth

☐ Lip or Cheek Biting ☐ Jaw Difficulty: Clicking and/or Pain

Child's Health History

Please check all that apply to your child:

☐ Allergies ☐ Diabetes ☐ Hepatitis – Type _____ ☐ Tuberculosis

☐ Anemia ☐ Epilepsy ☐ Rheumatic Fever ☐ Other _____

☐ Asthma ☐ HIV/AIDS ☐ Scarlet Fever _____

☐ Cancer ☐ Heart Murmur ☐ Tonsillitis _____

Primary Dental Insurance

Person Responsible for Account _____

Relationship to Patient _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Additional Insurance

Person Responsible for Account _____

Relationship to Patient _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

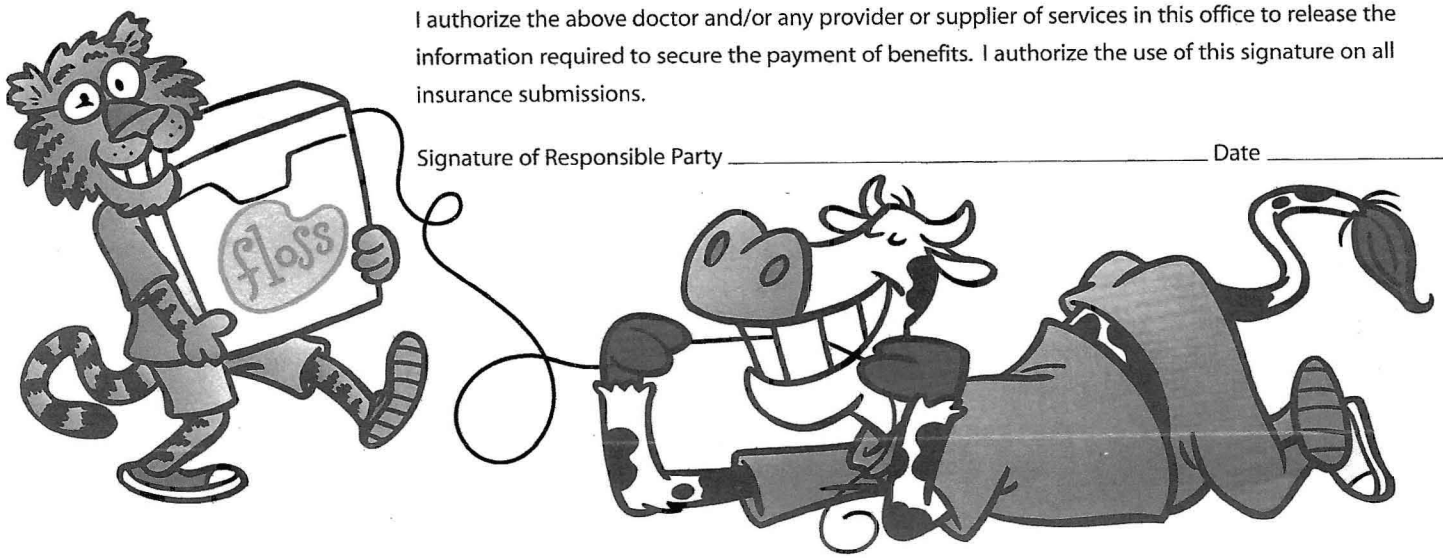
Subscriber I.D. # _____ Group # _____

Assignment and Release

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____



DENTAL HISTORY

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain ☐
- Tooth Pain ☐

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐

Please describe: _____

4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Chronic Fatigue Syndrome ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough - persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis-Type _____ ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Jaw Pain ☐
- Latex Sensitivity ☐
- Kidney Disease ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth on head/neck ☐
- Ulcer ☐
- Venereal Disease ☐

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

WELCOME
TO OUR PRACTICE!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Home Phone _____
Last Name First Name Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Please complete reverse side

ISLAND EAST DENTAL GROUP

STEPHEN D. FLUGER, DDS, PLLC

NUMBGUM@AOL.COM

Your Pharmacy Information:

Should you need medications....Where do you have your prescriptions filled?

Please complete the following information:

Your Name:_____

Your Address:_____

_____

Pharmacy Name:_____

Pharmacy Address:_____

Pharmacy Phone Number:_____

691 MONTAUK HIGHWAY
SHIRLEY, NY 11967
(631) 399-4470
(631) 399-1201 FAX
ISLANDEASTDENTALGROUP.COM

Please Read Carefully

Important Information Regarding Your Island East Dental Account

On Time payments are due on or before the 15th of the statement month, to avoid interest and/or late charges. *

Effective January 2000, all accounts that do not have or fail to abide by their specific payment arrangement, will be subject to the following terms and conditions. **By not paying at the time of treatment, you are asking to be billed and in doing so, you are accepting the terms and conditions as set forth.**

1. After thirty days **(30),** or commencing at the second billing cycle, whichever comes first, your account balance may be service charged. Your thirty day interval commences from the first date of treatment. Billing cycles and the date at which your account may accrue these charges, may not coincide. An interest rate of **2%** per month and a late fee of **$35** per month, may be imposed, if **NO** payment is received from **YOU**, independent of insurance company payments, during any billing cycle.*
2. **Out-of-pocket** costs are expected at each visit and deductibles are payable at the initial visit. **"Student"** certification required for those dependents covered under your policy verifying their eligibility is expected at their first visit.
3. A **$50** clerical fee will be incurred for each form that we file on your behalf, if the insurance information you gave to us is either incorrect or your coverage is found not to have been in effect at the time of treatment. It is **YOUR** responsibility to update this information and to keep track of your benefit usage at this office along with other providers, as it becomes necessary.

Claims filed on your behalf are filed as a courtesy in keeping with our agreement, if any, with your insurer. We cannot guarantee any estimated coverage. The insurance policy is an agreement between you and your insurance company. **All patients are directly responsible for all charges.** If for some reason your insurance company has not paid their portion within **30 days** from the start of the treatment, you are responsible for that portion and you may be billed the unpaid insurance balance accordingly.

4. **If your account is tendered to a collection agency, once contacted by the agency, NO FURTHER TREATMENTS WILL BE POSSIBLE! Emergency treatment ONLY will be available for thirty (30) days after the date your account is sent for collection action(s). "Courtesy discounts" afforded to you will be reversed, and you will be responsible for our standard fees for service as you will have broken our agreement to accept a lesser fee in exchange for timely payments.**
5. A returned check fee of **$35** will be assessed if your check is returned to us unpaid. A "***Broken Appointment***" fee of $35 is incurred without 24 hour notice.

- ***A minimum monthly payment is required from you: $ 75 per month or 30% of your outstanding balance, whichever is GREATER, exclusive of any payments received or anticipated from your insurer. This amount is to continue, paying your off your balance in (3) three months!***
- ***You do not recalculate this minimum each month unless additional out-of-pocket costs have been incurred!***

I am aware that payment for treatment and or co-payment are due at time of treatment.

Signature:_____ **Date:** _____