Welcome

We are delighted to welcome you to our practice and are pleased that you have chosen us to care for your dental needs. We will do our utmost to maintain an environment of trust and professionalism where you will feel welcome, well cared for and well informed.

Professionally, we have been serving the dental needs of patients in the New York City area for more than fifteen years and are very excited to share with you the best that dentistry has to offer today. We are confident in the services provided at our office. Our materials, equipment and sterilization techniques represent state of the art technology. Most importantly, we are sensitive to our patients' feelings and encourage open communication about your dental care.

Finances

Please understand that the amount of coverage you have is based on the type of policy and the benefit amount your employer has selected to fund.

We will file your insurance claims as a courtesy for you. Regardless of what we may calculate your insurance company to pay, it is only an estimate. The financial obligation for dental treatment is between you and this office, and its not between this office and your insurance company.

We will do all we can to get the maximum benefits reimbursed for you. Please be aware that some of the services provided may not be covered or may be considered above the "usual and customary". You are responsible for payment of your account, regardless of any insurance company's arbitrary determination of "usual and customary" fees.

When our professional services are rendered, you are responsible for payment at the time of treatment unless prior arrangements have been made with our financial coordinator. Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact that people have different needs in fulfilling their financial obligations, we are providing the following payment options.

Please ***Circle*** below the form of payment you wish to choose to settle your account.

1. Cash or Check
2. Visa/Mastercard/American Express/Discover/Debit Checking Card
3. Care Credit Finance Option

In the event that payment is not made and legal action is required, the patient shall be responsible for all legal fees, court costs and interest accumulation from the date of completion at 1% per month.

Appointments

We realize that occasionally things do occur that create changes in schedules, but ask that you please give us 2 Business Days Notice (excluding weekends) if the need to reschedule your appointment should arise. This will avoid a charge and will allow us to offer this time to another patient. With this notice, we can reschedule your appointment and let another patient have the appointment time originally reserved for you. Unless an emergency occurs, you can expect us to be on time. We appreciate you being prompt also.

Please let us know if you have any questions or concerns. We are here to make your experience as pleasant as possible.

Signature of patient responsible: _____

Date: _____

Frederick A. Stange, DDS
And Associates
210 East 47th Street
New York, NY 10017
212-888-3570

Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);

Obtaining payment from third party payers (e.g. my insurance company);
The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice Of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time, However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Frederick A. Stange, DDS
And Associates
210 East 47th Street
New York, NY 10017
Office: 212-888-3570
Fax: 212-888-0506
Web Site: CityDentist.com
Email: Reception@citydentist.com

Patient Information

(office use) Chart # _____

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Domestic Partner ☐ Other _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____(Work): _____Ext_____(Cell)_____

E-Mail Address _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for Today's visit:_____

Please check those that apply:

Allergic to:
- ☐ Amoxicillin
- ☐ Penicillin
- ☐ Codeine
- ☐ Latex
- ☐ Iodine

Plse List Other Allergies:
_____
_____

- ☐ Aids
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ X-ray Treatments
- ☐ Osteoporosis
- ☐ IV Bisphosphonate
- ☐ Zometa/Aredia treatment
- ☐ Congestive Heart
- ☐ Coumadin
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur/ MVP
- ☐ Hepatitis (A)(B)(C)
- ☐ High Blood Pressure
- ☐ HIV +
- ☐ Jaundice
- ☐ Joint replacement/pins Date: _____
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker

☐ Pregnancy
Due date:_____

- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Current Smoker QTY_____
- ☐ Previous Smoker How Long? _____
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Parkinson's Disease
- ☐ Medications presently taking :
  - ☐ _____
  - ☐ _____
  - ☐ _____

Date Reviewed & Updated Initials

_____ _____
_____ _____
_____ _____
_____ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you currently undergoing treatment of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
  Name of Physician: _____Phone:_____
- Name of Primary Care Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X_____ Date:_____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you? ☐ Patient ☐ Friend ☐ Relative ☐ Specialist ☐ Google ☐ Yelp ☐ Internet
Name:_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City State Zip Code

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

Insurance Plan Phone Number: _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name,Address and Phone Number:_____

_____

Consent and Agreement for Services

In this Consent for Services, "I" or "You" or the "Patient" are defined as the individual signing below in the space marked "Patient" or the parent or guardian of such "Patient" in the event same is a minor or has a guardian appointed for them. The "Office" or the Practice" or the "Doctor" are defined as Dr. Frederick Stange or Frederick Stange, DDS or Always Smiling, PC.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Patient accepts and understands the treatment plan as presented. Patient also accepts financial responsibility for all services rendered. Patient agrees that fees are due at the time services rendered. Insurance payments will be reimbursed directly to the patient (subscriber) by their insurance company. Patient is responsible to understand their own insurance coverage. Any separate financial arrangements must be made in writing.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent, or guardian

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And Associates
210 East 47th Street
New York, NY 10017
Office: 212-888-3570
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Patient Information

(office use) Chart # _____

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Domestic Partner ☐ Other _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____(Work): _____Ext_____(Cell)_____

E-Mail Address _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for Today's visit:_____

Please check those that apply:

Allergic to:
- ☐ Amoxicillin
- ☐ Penicillin
- ☐ Codeine
- ☐ Latex
- ☐ Iodine

Plse List Other Allergies:
_____
_____

- ☐ Aids
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ X-ray Treatments
- ☐ Osteoporosis
- ☐ IV Bisphosphonate
- ☐ Zometa/Aredia treatment
- ☐ Congestive Heart
- ☐ Coumadin
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur/ MVP
- ☐ Hepatitis (A)(B)(C)
- ☐ High Blood Pressure
- ☐ HIV +
- ☐ Jaundice
- ☐ Joint replacement/pins Date: _____
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker

- ☐ Pregnancy Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Current Smoker QTY_____
- ☐ Previous Smoker How Long? _____
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Parkinson's Disease
- ☐ Medications presently taking :
  - ☐ _____
  - ☐ _____
  - ☐ _____

Date Reviewed & Updated Initials
_____ _____
_____ _____
_____ _____
_____ _____

Pharmacy Name Phone Number and Location:
_____
_____
_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you currently undergoing treatment of a physician? ☐ Yes ☐ No
  If yes, please explain:_____

Name of Physician: _____Phone:_____

- Name of Primary Care Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X_____ Date:_____
Signature of patient, parent or guardian

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Name:_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

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The following is for: ☐ the patient ☐ the person responsible for payment

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Address: _____

Street City State Zip Code

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

Insurance Plan Phone Number: _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name,Address and Phone Number:_____

_____

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_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent, or guardian