Patient is responsible for co-pay. If patient exceeds his/her dental coverage, patient will be billed for the remainder of the fees.

Dr. Mr.
Mrs. Ms. First Name _____ Last Name _____

Birth Date _____ S.S.# _____

Home Address _____
Street Apt City State Zip Code

Email: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact Name /Relationship/Phone#

_____

Referred By _____

Employer/Occupation _____

Business Address _____
Street City State Zip Code

Dental Insurance Carrier _____ ID# _____

Group# _____

Pharmacy Information:

_____

For the following, please circle "Yes" or "No". Your answers are for our information and will be considered confidential.

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?

Heart Murmur	Yes No	Hepatitis	Yes No
Mitral Valve Prolapse	Yes No	Sinus Trouble	Yes No
Rheumatic Fever	Yes No	Diabetes	Yes No
Angina	Yes No	Glaucoma	Yes No
Arteriosclerosis	Yes No	Sexually Transmitted Disease	Yes No
High Blood Pressure	Yes No	Asthma	Yes No
Low Blood Pressure	Yes No	Urinary Infection	Yes No
Anemia	Yes No	Kidney Disease	Yes No
Bleeding Problems	Yes No	Ulcers	Yes No
Liver Disease	Yes No	Cancer	Yes No
Thyroid Disease	Yes No	Radiation Therapy	Yes No
Lung Disease (T.B.)	Yes No	Chemotherapy	Yes No

PLEASE ANSWER THE FOLLOWING QUESTIONS

1) Are you in good health? Yes No
2) Are you presently under the care of a physician? Yes No

   If so, for what condition?

   Date of last physical exam

3) Are you presently taking any drug or medicine? (include over the counter, vitamins, natural or herbal preparations, diet supplements) If so, please list them: Yes No
4) Do you drink alcoholic beverages? Yes No
5) Do you use tobacco products? Yes No

PLEASE COMPLETE OTHER SIDE

Patient is responsible for co-pay. If patient exceeds his/her dental coverage, patient will be billed for the remainder of the fees.

6) Have you ever been tested for H.I.V.? Yes No

Results of test POSITIVE NEGATIVE

7) Do you have heart trouble or cardiovascular disease? Yes No
8) Do you have damaged or artificial heart valves? Yes No
9) Have you taken an Echocardiogram? Date of Exam? Yes No
10) Do you require antibiotic coverage for dental procedures? Yes No
11) Do you have an artificial hip or other prosthetic device? Yes No
12) Do you have a Cardiac Pacemaker? Yes No
13) Do you experience chest pain upon exertion? Yes No
14) Do you routinely take aspirin on a daily basis? Yes No
15) Do you have a hearing problem? Yes No
16) Are you Pregnant? Yes or No What Month? Nursing? Yes No
17) Are you taking Birth Control Pills? Yes No

PLEASE CIRCLE ANY OF THE FOLLOWING DRUGS TO WHICH YOU MAY BE ALLERGIC:
PENICILLIN—AMOXICILLIN—AUGMENTIN—ERYTHROMYCIN--BIAXIN

ZITHROMAX—CLINDAMYCIN—CIPRO—FLAGYL—SULFUR—TETRACYCLINE

ASPIRIN--IBUPROFEN (MOTRIN, ADVIL) --ALEVE (NAPROXEN)--

CODEINE—VICODIN (HYDROCODONE) & TYLENOL (ACETAMINOPHEN)

LOCAL ANESTHETIC—NOVOCAINE--ADRENALIN (EPINEPHRINE)

LATEX--SEASONAL ALLERGIES--OTHER ALLERGIES

Name, address and phone # of Physician

_____

_____

NOTE: BOTH DOCTOR AND PATIENT ARE ENCOURAGED TO DISCUSS ANY AND ALL-RELEVANT PATIENT HEALTH ISSUES PRIOR TO TREATMENT.
I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT INQUIRIES SET FORTH ABOVE HAVE BEEN ANSWERED TO MY SATISFACTION. I WILL NOT HOLD MY DENTIST, OR ANY OTHER MEMBER OF HIS STAFF RESPONSIBLE FOR ANY ACTION THEY TAKE OR DO NOT TAKE BECAUSE OF ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

_____

PATIENT SIGNATURE/GUARDIAN DATE D.D.S. INITIALS

MEDICAL HISTORY UPDATE (TO BE FILLED OUT AT FUTURE VISITS) ***
PLEASE NOTE ANY CHANGES IN MEDICATIONS OR ALLERGIC REACTIONS AND WRITE THEM BELOW.
PLEASE SIGN AND DATE EVEN IF THERE ARE NO CHANGES AT FUTURE VISIT. ***

_____

PATIENT SIGNATURE/GUARDIAN DATE D.D.S. INITIALS

PLEASE COMPLETE OTHER SIDE

ENDODONTIC ASSOCIATES of BROOKLYN HEIGHTS, PC

185 MONTAGUE STREET • 9TH FLOOR • BROOKLYN, NY 11201-3614 • TEL (718) 638-5100 • FAX (718) 638-5192

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. I hereby acknowledge that upon my request, I will receive a copy of the practice's Notice of Privacy Practices.

The terms of the notice may change, if so, you will be notified on your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time, and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

COMMUNICATION PREFERENCES:

Please select your communication preference (please select all that apply): ☐ **PHONE** ☐ **TEXT** ☐ **EMAIL**

May we leave a message on your answering machine at home or on your cell phone? ☐ **YES** ☐ **NO**

May we leave a message to discuss your dental treatment with any family member at the number you provided? ☐ **YES** ☐ **NO**

If **YES,** please name the members allowed:

PRIVACY POLICY

(EFFECTIVE DATE: 1/13/26)

Endodontic Associates of Brooklyn Heights ("we," "us," "our") respects your privacy and is committed to protecting your information. This Privacy Policy explains how we collect, use, and share information when you opt in to receive SMS messages from us. When you opt in, we collect your phone number and consent to send SMS messages. We use your information to send you the messages you've opted to receive, provide updates, or other relevant content based on your preferences. We do not share your phone number or SMS opt-in information with third parties for marketing purposes. You can opt out of receiving SMS messages at any time by replying with "STOP" to any message we send you. We implement reasonable measures to protect your personal information from unauthorized access or disclosure. If you have questions or concerns about our privacy practices, contact us at (718) 638-5100.

***PLEASE TURN OVER TO BACK OF PAGE FOR MORE →**

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TERMS AND CONDITIONS

(EFFECTIVE DATE: 1/13/26)

By opting in to receive SMS messages from [Your Company Name] ("we," "us," "our"), you agree to the following terms:

1. SMS Messaging Service
By providing my phone number, I consent to receive SMS text messages from Endodontic Associates of Brooklyn Heights PC for appointment reminders and general two-way communication. Msg frequency varies. Msg&data rates may apply. Reply HELP for support. Reply STOP to opt out.

2. Message Frequency
You will receive up to 15 messages per month.

3. Message and Data Rates
Message and data rates may apply based on your mobile carrier's terms.

4. Privacy Policy
Your information will be handled in accordance with our Privacy Policy, which can be viewed at www.endodonticassocatesofbk.com.

5. Opt-Out Instructions
You can opt out at any time by replying "STOP" to any SMS message. Reply HELP for support. You may also contact us directly at (718) 638-5100.

6. Liability
We are not responsible for any charges, errors, or delays in SMS delivery caused by your carrier or third-party service providers.

By opting in, you confirm that you are the owner or authorized user of the phone number provided and that you are at least 18 years old.

PATIENT CONSENT:
"I consent to receive SMS text messages from Endodontic Associates of Brooklyn Heights to the number provided for appointment reminders, and general two-way communication. Msg frequency varies. Msg&data rates may apply. Reply HELP for support. Reply STOP to opt out. See our privacy policy for more information." ☐ **I CONSENT** ☐ **I DO NOT CONSENT**

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ **Date:** _____

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DR. STANLEY MICHEL, DMD* • DR. MICHELE NGUYEN, DDS* • DR. ROBERT GOLDBERGER, DDS* • DR. MONA JOODI, DMD
Diplomates of American Board of Endodontists*

Credit Card Authorization Form

Dear Insurance Subscriber,

We **require** that a credit card be left on file to ensure **complete** reimbursement for the services we provided. A receipt and Explanation of Benefits (EOB) will be emailed to you if there are any remaining out-of-pocket expenses.

PLEASE NOTE: Post removals and nitrous oxide are not covered by insurance and are considered out-of-pocket expenses. If you require a post removal, please note the cost is $600. If you opt to use nitrous oxide for your treatment, the cost is $300.

Credit Card Billing Information

Patient Name: _____

Credit Card Type: ( )Visa; ( ) MasterCard; ( ) American Express; ( ) Discover; ( ) Other _____

Cardholder's Name: _____

Credit Card Number: _____

Expiration Date: ____/_____ **Billing Zip Code**:_____

Credit Card CVC Number (3-digit number on the back of the card): _____

I hereby authorize Endodontic Associates of Brooklyn Heights PC to bill my credit card for services rendered after insurance pay-out. Payee will receive their EOB (Explanation of Benefit) and payment receipt via email. Applicant agrees that all information provided is accurate and complete.

Signature: _____ **Date**: _____