

Robert Herzog, D.D.S.  
Tricia Primomo, D.D.S.



Dental Wellness  
of Albany

651 Delaware Avenue  
Albany, New York 12209  
(518) 427-2447 • FAX 427-7346

Patient Name \_\_\_\_\_ male /female Date \_\_\_\_\_ Birthdate \_\_\_\_\_  
Name you would preferred to be called \_\_\_\_\_ single married separated divorced

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Circle best way to reach you during the day?

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Last 4 digits of SS# \_\_\_\_\_

Who is responsible for account? \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Name of parent if child \_\_\_\_\_

Emergency contact and number \_\_\_\_\_

**Insurance information:**

Please present your Insurance Card and Driver's License to the administrator.

**Dental Information:**

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

Circle YES if have or had the below conditions or issues:

- |                                   |  |
|-----------------------------------|--|
| Gums bleed flossing or brushing   | Teeth sensitive to biting, hot or cold |
| Feel pain in any of your teeth    | Head or neck injuries                  |
| Frequent Headaches                | Clench or Grind teeth                  |
| Difficult extraction in past      | Sore or lumps in mouth                 |
| Orthodontics                      | Concerned about bad breath             |
| Do your wear dentures or partials | Would you like whiter teeth            |

**Consent to Treatment and Policies**

I attest that my submitted medical history is accurate and agree to provide updates to my medical and dental condition at future appointments. I hereby authorize Dr. Herzog or Dr. Primomo to perform any and all forms of treatment, medication and therapy that may be indicated in connection with my dental care and further authorize and consent that the doctor chooses and employs such assistance as he deems fit within the scope of practicing dentistry. I understand that prior to treatment, full explanation of the procedures involved will be given by the doctor and/or his staff.

Our practice understands that patients rely on their dental insurance to help defray the costs of dental services. We agree to council patients about what insurance can do to assist them in paying for services and to explain any plan limitation to the best of our knowledge. It is ultimately your responsibility to fully understand the advantages and limitations of your own insurance plan. Please understand that our follow-up process is limited to rebilling insurance companies one time. We agree to be efficient in our processing steps with accurate information that you provide. However, if a claim is not paid after 60 days, the patient will be responsible for full payment and may choose to collect from their own insurance company. A finance charge will be added to your account 30 days overdue.

We reserve the right to reschedule an appointment if the patient arrives after their appointed time. Missed and/or cancelled appointments without 24 hours notice may result in you being dismissed as a patient as well as repeatedly ignoring suggestions from the doctor. A new patient is not considered a patient of record until they have had an initial new patient exam and an appropriate cleaning. After a 3 year absence, your records will be placed in the inactive file and will require re-admittance through the new patient procedure. Our goal is to provide you with optimal oral health and requires commitment on both the patient as well as the doctors.

Signature of responsible party \_\_\_\_\_ relationship \_\_\_\_\_ date \_\_\_\_\_

[www.651Dental.com](http://www.651Dental.com)

*Our goal is to provide our patients with quality treatment in a relaxed friendly atmosphere.*