



Paul Lonstein, D.M.D., P.C.

Fellow Academy of General Dentistry
42 Canal Street, PO Box 288
Ellenville, New York 12428-0288
845.647.2222 Facsimile 845.647.2237

Dear Patient:

- We would like to welcome you and let you know how pleased we are that you considered us to care for your dental health.
- ***The enclosed patient information and health questionnaire can be completed at your convenience, please bring it with you to your appointment.*** For children (less than 18 years old), the parents or guardians must sign the back of the health questionnaire, since the child is a minor.
- If you recently had x-rays of your teeth and they are current (complete mouth x-rays taken within three years, bitewing x-rays not older than one year), you should request a copy from your previous dentist and have them e-mailed to our office.
- Our e-mail address is barbara@drlonstein.com.
- ***If your employer has dental insurance, all pertinent information must be provided to our office prior to your appointment so that coverage may be verified.*** Please complete a dental insurance form and bring it with you at your appointment visit. You will be responsible for any deductible and co-payment if your insurance requires it at time of visit. Please understand your dental insurance. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. In the event that we do accept assignment of benefits and your insurance company has not paid your account in 45 days, the balance will be automatically transferred to your account.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- Please note that this appointment has been reserved for you. We appreciate a 24-hour or more notice if you cannot keep this appointment, so that we can schedule another patient who is in need of dental care. No charge will be made for cancellation of appointment if a 24-hour notice is given.
- We are looking forward to seeing you soon.

Sincerely,
Paul Lonstein, DMD And Dental Team



Welcome to the Dental Office of
Paul Lonstein, D.M.D., P.C.
Fellow Academy of General Dentistry

PLEASE PRINT IN PEN INK

NEW PATIENT NAME AND INFORMATION

Today's Date _____ E-mail Address (for Statements) _____

Name _____ Male Female I prefer to be called: _____
Last First MI Mr Mrs Ms Dr (circle one)

Birthdate ____ - ____ - ____ Age _____ Social Security # _____

Home Address _____
Street PO Box City State Zip

We may call you at:
Home Phone #(____) Pager/Cell #(____) Work Phone #(____)

Best time to reach you? _____ Whom can we thank for referring you? _____

Landlord Name: _____ Telephone: _____

Employer: _____ How Long there? _____ Occupation: _____

Employers address: _____
Street/PO Box City State Zip

Whom can we call in case of Emergency?

His/Her Name _____ Relation _____ Work # _____ Home Phone # _____

Address _____
Street City State Zip

Spouse Information

His/Her Name: _____ Birthdate ____ - ____ - ____ Social Security # _____

Employer: _____ Work Phone # (____) _____

Local Pharmacy

Name Address Telephone #

Insurance Information

Primary Insurance: Dental Coverage? Yes No (please circle)

Insurance Co Name _____ Phone # (____) _____ Group # (Plan, Local, or Policy #) _____

Insurance Co Address _____
Street/PO Box City State Zip

Insured Name: _____ Insured Social Security # _____ Insured Birthdate ____ - ____ - ____

Relation? _____ Insured Address: _____

Insured Employer _____ Employer's Address _____
Street/ PO Box City State Zip

Secondary Insurance: Dental Coverage? Yes No (please circle)

Insurance Co Name _____ Phone # (____) _____ Group # (Plan, Local, or Policy #) _____

Insurance Co Address _____
Street/PO Box City State Zip

Insured Name: _____ Insured Social Security # _____ Insured Birthdate ____ - ____ - ____

Relation? _____ Insured Address: _____

Insured Employer _____ Employer's Address _____
Street/ PO Box City State Zip

Paul Lonstein DMD PC
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Ellenville New York 12428
845-647-2222

Dental Office Financial Policy

Our dental office prides itself on offering exceptional care and service to our patients in a timely manner. We expect payment in full at the time of service. For your convenience, we accept cash, personal checks, MasterCard, Visa, Discover Card and Care Credit.

By signing below, I understand that it is my responsibility to pay the balance for my dental visit in full on the day of my appointment.

All other payment arrangements must be made in advance of your visit.

My balance will be paid in full today (on the day of my appointment) by (**please CHECK one**):

- Cash
- Personal Check
- MasterCard
- Visa
- Discover
- Care Credit

Signature: _____

Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Paul Lonstein DMD PC

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
 - Communications barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Please Specify)
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Receipt of Notice of Privacy Practices.doc