PATIENT INFORMATION

Welcome to our office. So that we may assist you in filing your health insurance forms, please provide us with the information requested below. All information is kept confidential.

Patient's Name:_____ Today's Date_____

Sex:_____ Age:_____ Birth Date: _____ Soc. Sec. #_____

Address:_____ **Apt #:**_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Spouse's Name_____

Email: _____

Pharmacy Name: _____

Pharmacy Address: _____

Fill this out **ONLY** if you are not the Responsible Party for the Insurance Policy:

Responsible Party's Name:_____ Soc. Sec. #_____

Birth Date:_____ Relationship to Insured:_____

Address:_____

City:_____ State:_____ Zip:_____

Name of **Dental** Insurance:_____ Group Number:_____

Employer:_____ Occupation:_____

Referring Dentist:_____

Address:_____

City:_____ State:_____ Zip:_____

Orthodontist:_____

Reason for Visit:_____

How did you hear about us? :_____

_____

MEDICAL HISTORY FORM

Name:_____ Date:_____

Date of Birth: _____ Sex: M / F S.S.#: _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be kept confidential.

1. Are you in good health? ..... Yes No
2. Has there been any change in your health in the past year? ..... Yes No
3. My last physical exam was on _____/____/_____
4. Are you now under the care of a physician? ..... Yes No
   If so, or what condition? _____
5. The name and phone # of my physician is:_____
   _____
6. Have you had any serious illness, operation or hospitalization within the past 5 years? ..... Yes No
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? ..... Yes No
8. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia or Zometa) ? ..... Yes No
9. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies? ..... Yes No
   If so, please list: _____
   _____
10. Do you have or have you had any of the following diseases or problems?
    a. Damaged heart valves, artificial valves or heart murmur ..... Yes No
    b. Rheumatic Heart Disease ..... Yes No
    c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition ..... Yes No
       1. Chest pain upon exertion? ..... Yes No
       2. Shortness of breath after mild exercise? ..... Yes No
       3. Do your ankles swell? ..... Yes No
    d. Allergies ..... Yes No
    e. Sinus trouble ..... Yes No
    f. Asthma or hay fever ..... Yes No
    g. Fainting spells or seizures ..... Yes No
    h. Diabetes ..... Yes No
    i. Hepatitis, jaundice or liver disease ..... Yes No
    j. Frequent or recurring mouth sores ..... Yes No
    k. Thyroid problems ..... Yes No
    l. Respiratory problems, emphysema, bronchitis, etc. ..... Yes No
    m. Arthritis or painful, swollen joints including jaw joint (TMJ) ..... Yes No
    n. Osteoporosis ..... Yes No
    o. Stomach ulcer or hyperacidity ..... Yes No
    p. Kidney trouble ..... Yes No
    q. Tuberculosis ..... Yes No
    r. Persistent cough or cough that produces blood ..... Yes No
    s. Persistent swollen neck glands ..... Yes No

t. Low blood pressure ..... Yes No
u. Epilepsy or neurological disorder ..... Yes No
v. Cancer ..... Yes No
w. Any disease, drug or transplant operation that has depressed your immune system ..... Yes No

11. Have you had abnormal bleeding? ..... Yes No
    a. Have you ever required a blood transfusion? ..... Yes No
12. Do you have any blood disorder such as anemia? ..... Yes No
13. Have you ever had treatment for a tumor or growth? ..... Yes No
14. Have you had radiation therapy to the head, neck or jaws? ..... Yes No
15. Are you allergic to or have you had a reaction to:
    a. Local anesthetics ..... Yes No
    b. Penicillin or antibiotics ..... Yes No
    c. Sulfa drugs ..... Yes No
    d. Barbiturates or sleeping pills ..... Yes No
    e. Aspirin ..... Yes No
    f. Iodine ..... Yes No
    g. Codeine or other narcotics ..... Yes No
    h. Latex or rubber products ..... Yes No
    i. Other ..... Yes No
16. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
    If so, explain: _____
    _____
17. Do you have any other condition or disease you think the doctor should know about? ..... Yes No
    If so, explain: _____
18. Do you smoke or chew Tobacco? ..... Yes No
    How much? _____
19. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? ..... Yes No
20. Do you wish to talk with the doctor privately about anything? ..... Yes No

Women

21. Are you pregnant or trying to become pregnant ..... Yes No
22. Do you have problems associated with your menstrual period? ..... Yes No
23. Are you nursing? ..... Yes No
24. Are you taking birth control pills? ..... Yes No

Chief Dental Complaint: _____
_____

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date: _____ Patient's Signature: _____

Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:

A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:

We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact **Joan Garrison at 212-245-5801,** in person or in writing, during normal hours. She will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;

- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact **us at 212-245-5801.**

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to **MMSG.** You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address and phone number is **26 Federal Plaza New York, NY 10278.**

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)

We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Public Health

As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional Institutions

If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Website

If we maintain a website that provides information about our entity, this Notice will be on the website.

Effective Date: April 17, 2009

I, _____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

Name Date

Financial Policy

We are pleased to welcome you to our office. New patients are always appreciated. In order to assist you in making payments for your treatment, we provide the following options. Please read them carefully, and feel free to discuss them with us.

PAYMENT: We accept all major credit cards, care credit and cash.

IF YOU ARE INSURED: If we are In-Network with you insurance carrier, we will honor the In-Network fees you will be responsible for services rendered at the time of service. As a courtesy, we will submit your form to your insurance carrier on your behalf. Reimbursement by the insurance company will be paid directly to the patient.

INSURANCE PATIENTS- PLEASE READ CAREFULLY: The amount of coverage paid by your insurance company may be based on your insurance company's own reduced fee schedule for treatment and may be less than actual charges resulting in lower coverage to you. We have no control over this situation. Lower payment is a direct result of the plan selected by your employer.

EXTENDED CARE CASES: Special arrangements may be made for extended care cases. Please see our Office Administrator.

FINANCIAL CONSENT: I certify that I have read, understood, and agree to this financial policy, and that it applies to myself and my dependents.

Responsible Party's Signature: _____

Date: _____