Patient Information

Patient Name: ______________________________ Date: ____________________
Last First MI

Male Female Married Single Child Other ______________________________

Social Security # ______________________________ Birth Date ______________

Phone (Home): ______________ (Cell): ______________ (Work): ____________

Email Address: ____

Address: ____
Street Apartment

____
City State Zip Code

Spouse or Responsible Party Information

Name: ______________________________ Date: ____________________
Last First MI

Male Female Married Single Child Other ______________________________

Social Security # ______________________________ Birth Date ______________

Phone (Home): ______________ (Cell): ______________ (Work): ____________

Email Address: ____

Address: ____
Street Apartment

____
City State Zip Code

Employment Information

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

Employer Name: ____

Address: ____

Insurance Information

Name of Insured: ____
Last First MI

Insured's Birth Date: ______________ ID/SSN: ______________ Group #: ______________

Insurance Company: ____

Relationship to Insured: Self Spouse Child Other

Health History

Date of Last Dental Visit ____________ Reason for This Visit ____

Is there anything about your smile that you do not like? ____

Do your gums bleed? YES NO

Have you ever had any of the following? Please check those that apply:

AIDS	Growths	Respiratory Problems
Allergies ______________	Hay Fever	Rheumatic Fever
_______________________	Head Injuries	Rheumatism
Anemia	Heart Disease	Sinus Problems
Arthritis	Heart Murmur	Stomach Problems
Artificial Joints	Hepatitis	Stroke
Asthma	High Blood Pressure	Tuberculosis
Blood Disease	Jaundice	Tumors
Cancer	Kidney Disease	Ulcers
Diabetes	Liver Disease	Venereal Disease
Dizziness	Mental Disorders	Codeine Allergy
Epilepsy	Pacemaker	Penicillin Allergy
Excessive Bleeding	Pregnancy	OTHER: _____________________
Fainting	(DUE DATE____________)	______________________________
Glaucoma	Radiation Treatment	

- Please list any medications you are currently taking: ____
- Have you ever had any complications following dental treatment? YES NO
  If yes, please explain: ____
  ____
- Are you now under the care of a physician? YES NO
- Have you been admitted to a hospital or needed emergency care during the past two years? YES NO
  If yes, please explain: ____
  ____
- Name of 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.

____ **Date**_____________________________________

Signature of patient, parent, or guardian

*Whom may we thank for referring you to our practice? ____

449 Piermont Ave
Piermont, NY 10968
(845) 365-4270

Office Policy Acknowledgement

Piermont Dental, P.C. understands the value of insurance benefits to our patients and we gladly accept assignment of those benefits with participating insurance plans. We will do our best to estimate your deductible and the portion that may be covered by your insurance carrier. **Please keep in mind that rarely does an insurance company cover an entire fee, and that each carrier sets their own limitations on the maximum amount they will pay for each procedure based on the type of policy purchased by your employer. Any balance remaining is your direct responsibility, as are any non-covered charges, deductibles and co-payments. We do not accept any insurance carrier's fees as payment in full. Since it is impossible for us to be familiar with the details of every insurance plan, we ask that you be aware of your financial responsibilities under these terms of your policy.**

Payment is due at the time services are rendered. If you need to make financial arrangements, please do so with the office staff prior to the start of treatment.

Retainers for Treatment Involving Lab Work: We require a retainer of half the fee for any treatment involving laboratory work. (e.g., crowns, bridges, dentures, etc.)

We offer several payment options for non-covered expenses, or uninsured patients, including Visa, MasterCard, American Express, and Discover. Treatment plans over $5,000.00 can also be financed through Care Credit or Chase Health Advance. If you have a "discount plan" or opt to participate with our In-House Dental Plan, we cannot accept Care Credit or Chase Health Advance.

Please be advised, if you need to cancel your appointment, please give us 24 hours notice in order to accommodate other patients or a broken appointment fee of $50 may be applied to your account. If you are more than 15 minutes late to your appointment, we may need to reschedule your appointment and the broken appointment fee of $50 may apply.

Should you account be turned over to a collections agency for nonpayment, you agree to pay any fees that the collections agency charges to our office.

There is a $30 charge for all returned checks.

Necessary radiographs for proper diagnosis are needed. Insurance companies sometimes require copies of radiographs and clinical notes in order to process claims. The submission of radiographs and notes to third party insurance companies is done so in a manor compliant with HIPAA regulations.

Thank you for giving us the opportunity to provide dental services to you.

Name	**Signature**	**Date**

449 Piermont Ave
Piermont, NY 10968
(845) 365-4270

HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE READ IT CAREFULLY.

Effective April 14, 2003, the US government regulators established privacy rule ("HIPAA") governing protected health information (PHI). This notice tells you about how it may be used, and about certain rights that you have.

USE AND DISCLOSURE OF PROTECTED INFORMATION:

1. Federal law provides that we may use your medical information (PHI) for treatment to you, without further specific notice to you, or written authorization by you. For example: If we refer you for an MRI we may provide test data to that facility (subject to more stringent New York State laws, such as restriction on disclosure of information concerning HIV/AIDS).
2. Federal law provides that we may use your medical information to obtain payment of our services without further specific notice to you, or written authorization by you. For example: Under your health plan, we are required to provide them with a diagnosis code for your visit and a description of the services rendered.
3. Federal law provides that we may use your medical information, without further notice to you or specific authorization by you, where:
    - A. Required by law;
    - B. Required by public health purposes;
    - C. Required by law to report child abuse;
    - D. Where required by a health oversight agency for oversight activities authorized by law, such as the Dept. of Health, Office of Professional Discipline, or Office of Professional Medical Conduct;
    - E. Required by law in judicial or administrative proceedings;
    - F. Required for law enforcement purposes by a law enforcement official;
    - G. Required by a coroner or medical examiner;
    - H. Permitted by law to a funeral director;
    - I. Permitted by law for organ donation purposes;
    - J. Permitted by law to avert a serious threat to health or safety;
    - K. Permitted by law and required by military authorities if you're a member of the armed forces of the United States;
    - L. Research purposes.

New York State law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information. Unless instructed by you, we may contact you by mail or phone at your residence of place of

employment, regarding your appointments, outstanding bills, or provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence of place of employment.

You can make reasonable requests, in writing, for us to use alternative methods of communication with you in a confidential manner. Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

RIGHTS THAT YOU HAVE:

You have the right to request restrictions on certain of the uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information (PHI). A reasonable fee will be charged for these copies.

You have the right to request amendments to your medical information. Such requests must be made in writing and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we ask of your medical information (PHI) except for: Disclosures we make to you, or to carry out treatment, payment of health care operations, or as requested by your written authorization, or as permitted or required under 45CFR 164.502, or for emergency or notification purposes, or for national security or intelligence purposes, as permitted by law, or to correctional facilities or law enforcement officials as permitted by law (or for research or public health purposes after being de-identified or limited to remove personally identifiable information), or disclosures made before April 14, 2003.

THIS BROCHURE IS PROVIDED FOR YOUR REVIEW TO COMPLY WITH THE REQUIREMENTS BY LAW TO MAINTAIN THE PRIVACY OF PROTECTED HEALTH INFORMATION (PHI) AND TO PROVIDE INDIVIDUALS WITH NOTICE TO OUR LEGAL DUTIES AND PRIVACY PRACTICES.

WE ARE REQUIRED TO ABIDE BY THESE TERMS OF THIS NOTICE AS LONG AS IT IS CURRENTLY IN EFFECT.

The office of Piermont Dental has made available for review a copy of the Health Insurance Portability and Accountability Act (HIPAA) with regard to the use and/or disclosure of certain protected health information (PHI) about me.

Patient: ____ Date: ______________

Signed by: ____

Patient or legal guardian