PATIENT INFORMATION FORM

DATE ______________

PATIENT LAST NAME: ____________________________ FIRST NAME: ____________________

HOME ADDRESS: ____

MAILING ADDRESS: ____

HOMEPHONE: ______________ WORKPHONE: ______________ CELLPHONE: ______________

BEST NUMBER TO
CONFIRM APPT. ____________ SS# _________________ DRIVERS LICENSE # _____________

MARITAL STATUS: _______ SEX: M F DOB: _______________

SPOUSE _________________________

EMPLOYER NAME ___________________________ REFERRED BY ___________________

PARENT/GUARDIAN: (required for all patients under the age of 18)

LAST NAME: ____________________________ FIRST NAME: ____________________

PRIMARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: ____

RELATION TO PATIENT: ______________ SS#: _____ - _____ - _________ DOB: ___/___/___

EMPLOYER NAME AND ADDRESS: ____

INSURANCE COMPANY NAME AND ADDRESS: ____

GROUP #: ________

SECONDARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: ____

RELATION TO PATIENT: ______________ SS#: _____ - _____ - _________ DOB: ___/___/___

EMPLOYER NAME AND ADDRESS: ____

INSURANCE COMPANY NAME AND ADDRESS: ____

GROUP #: ________

Name____________________
DOB ____________________

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

1. Are you in good health? .... Yes No
2. Have there been any changes in your general health within the past year? .... Yes No
3. My last physical exam was on ____________________
4. Are you under the care of a physician? .... Yes No
   If so, what is the condition treated? ____________________
5. The name and address of my physician(s) is ____________________
   ____
   ____
6. *Have you had any serious illness, operation, or been hospitalized in the past 5 years?* .... *Yes No*
7. *Are you taking any medicine(s) including non-prescription medicine?* .... *Yes No*
   *If so, please list all medications*____________________
8. *Do you have or have you had any of the following diseases or problems?*
   - **a.** *Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease* .... *Yes No*
   - **b.** *Cardiovascular disease(heart trouble, heart attack angina, coronary occlusion, high blood pressure, arteriosclerosis, stroke)* .... *Yes No*
     1. *Do you have chest pain upon exertion?* .... *Yes No*
     2. *Are you ever short of breath after mild exercise or when lying down?* .... *Yes No*
     3. *Do your ankles swell?* .... *Yes No*
     4. *Do you have inborn heart defects?* .... *Yes No*
     5. *Do you have a cardiac pacemaker?* .... *Yes No*
   - **c.** Allergy .... Yes No
   - **d.** Sinus trouble .... Yes No
   - **e.** Asthma or hay fever .... Yes No
   - **f.** Fainting spells or seizures .... Yes No
   - **g.** Persistent diarrhea or recent weight gain.................... Yes No
   - **h.** Diabetes .... Yes No
   - **i.** Hepatitis, jaundice, or liver disease .... Yes No
   - **j.** AIDS, or HIV infection .... Yes No
   - **k.** Thyroid problems .... Yes No
   - **l.** Respiratory problems, emphysema, bronchitis, etc. .... Yes No
   - **m.** Arthritis .... Yes No
   - **n.** Stomach ulcer or hyper acidity.................... Yes No
   - **o.** Kidney trouble .... Yes No
   - **p.** Tuberculosis .... Yes No
   - **r.** Persistent swollen glands in neck .... Yes No
   - **s.** Low blood pressure .... Yes No
   - **t.** Sexually transmitted disease .... Yes No
   - **u.** Epilepsy or neurological disease.................... Yes No
   - **v.** Problems with the mental health .... Yes No
   - **w.** Cancer.................... Yes No
   - **x.** Problems with the immune system .... Yes No
9. Have you had abnormal bleeding? .... Yes No
   - **a.** Have you ever required a blood transfusion? .... Yes No
10. Do you have any blood disorder such as anemia? .... Yes No
11. Have you ever had any treatment for a tumor or growth? .... Yes No

12. Are you allergic or have you had a reaction to:
  a. Local anesthetics .... Yes No
  b. Penicillin or other antibiotics .... Yes No
  c. Sulfa drugs .... Yes No
  d. Barbiturates, sedatives or sleeping pills .... Yes No
  e. Aspirin .... Yes No
  f. Iodine .... Yes No
  g. Codeine or other narcotics .... Yes No
  h. Other ________ Yes No
13. Have you had any serious trouble associated with any previous dental treatment? .... Yes No
If so, explain ________
14. Do you have any disease, condition, or problem not listed above that you think I should know about? .... Yes No
If so, explain ________
____
15. Are you wearing contact lenses? .... Yes No
16. Are you wearing removal dental appliances? .... Yes No

Women

17. Are you pregnant? .... Yes No
18. Do you have any problems associated with your menstrual period? .... Yes No
19. Are you nursing? .... Yes No
20. Are you taking birth control? .... Yes No

Chief Dental complaint ________
____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

____
Signature of Patient
Date________

For Completion by the dentist:

Comments on patient interview concerning medical history: ________
____

Significant findings from questionnaire ________

Dental management considerations: ________

________ Date

________ Signature of Dentist

Medical History Update:

Date	**Comments**	**Signature**
________	________	________
________	________	________
________	________	________

Protecting Your Confidential Health Information is Important to Us

Notice of Privacy Practices

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

Our Promise!

Dear Patient:
This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA - Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed? Why a privacy policy now? Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

How your HEALTH INFORMATION may be used

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgment

Patient Name(s): ______________________________

____

____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

____
Patient Signature
Date ______ / ______ / ______

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

James M. Ross, D.D.S.
Adam Donovan, D.D.S.
84 West Market Street
Red Hook, New York 12571
(845) 758-5100
Fax: (845) 758-5127

Financial Policy

Patients and/or guardians thereof are solely responsible for their dental bill. For your convenience, we accept Master Card and Visa in addition to cash and personal checks. If you have insurance, we'll gladly provide documentation so you can arrange to be reimbursed.
Accounts are due and payable monthly as treatment progresses, regardless of insurance coverage. A finance and billing charge will be added to the account after 30 days unless other arrangements have been made.
If your account becomes delinquent, you will be held responsible for any additional collection charges, finance charges, and/or attorney fees in the collection of your debt.

I understand and agree to the above: ________________________________Date_______________

Red Hook Family Dental

84. W. Market St.
Red Hook, NY 12571

NO SHOW/LATE CANCELLATION POLICY

Patient Name: ________________________________

We are committed to meeting our patients' health care needs. No-show and late cancellations waste precious time that other patients could use. Please be advised of our office policy.

All appointments must be cancelled by noon of the previous day (or by 10:00 am Friday for a Monday appointment) to avoid charges for a no-show or late cancellation. **PLEASE NOTE:** Insurance does not cover charges for no-show/late cancellation fees: therefore, the patient is responsible for payment.

~A NO SHOW/LATE CANCELLATION fee of $75.00 will be charged to the patient~

<u>Billing Questions:</u>

If you have any questions regarding billing, please call our office at 845-758-5100, during regular business hours.

I have read this document and understand that I will be financially responsible for the following:

- All missed scheduled appointments that are not cancelled as described in the policy above.

______________________________   ______________________________

Patient/legal guardian signature   Date

Thank you for your continued support of our practice.