Dutch Neck Dental

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

SS# _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate_____ Home Phone (_____) _____

Address _____City_____ State_____ Zip_____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single
☐ Separated ☐ Divorced ☐ Minor
☐ Partnered for _____years

E-mail _____Cell Phone (_____) _____

Employer/School_____ Employer Phone (_____) _____

Employer Address_____City_____State_____ Zip_____

Spouse or Parent's Name_____ Employer_____ Work Phone (_____) _____

Driver's License#_____ Whom may we thank for referring you? _____

Person to contact in case of emergency_____ Phone (_____) _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account_____ Relation to Patient _____

Address_____ City/State_____ Zip_____

Primary Phone (_____) _____ Birthdate_____ E-mail_____

INSURANCE INFORMATION

Name of Insured _____ ☐ Self ☐ Spouse ☐ Child ☐ Other

Birthdate _____Social Security # _____ Subscriber ID # _____

Employer _____ Work Phone (_____) _____

Insurance Company _____Group # _____

Address _____ City _____State _____Zip _____

ADDITIONAL INSURANCE

Name of Insured _____ ☐ Self ☐ Spouse ☐ Child ☐ Other

Birthdate _____ Social Security # _____ Subscriber ID # _____

Employer _____ Work Phone (_____) _____

Insurance Company _____Group # _____

Address_____ City _____State _____ Zip _____

-OVER-

Dutch Neck Dental

DENTAL HISTORY

Reason for today's visit _____Date of last dental care_____

Former Dentist _____Date of last dental X-rays_____

Check ☑ if you have had problems with any of the following:

- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between the teeth
- ☐ Jaw Pain
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Bad breath
- ☐ Grinding teeth

How often do you floss? _____ How often do you brush_____

MEDICAL HISTORY

Physician's Name _____Date of last visit_____

Have you had any serious illnesses or operations? ☐ Yes ☐No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐No If yes, give approximate dates_____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Are you currently taking any of the group of drugs collectively known as "bisphosphonates?" These include Fosamax, Reclast, Zometa, Actonel and Boniva. ☐ Yes ☐ No Have you ever taken any of these medications? ☐ Yes ☐ No How long ago? _____

Check ☑ if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints, Pins, etc.
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Skin Rash
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

List any necessary explanations for health conditions checked above or any other health conditions that are not listed:

_____

_____

List medications you are currently taking and the correlating diagnosis:

_____

_____

Allergies:

_____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s) assign directly to Dr. Goldstine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

Dutch Neck Dental

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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/03), and will remain in effect until we replace it.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Your Authorization: In addition to our use of your health information for treatment , payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Marketing Health-Related Services: We will not use your health information for marketing communications.

Required by Law: We may use or disclose your health information when we are required to do so by law.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment and Medication Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Dutch Neck Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.
{Please 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)

_____

_____

_____

Dutch Neck Dental

Authorization and Consent
To Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell Dutch Neck Dental in writing to stop, I authorize Dutch Neck Dental to transmit patient information relating to my treatment and/or health by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, or Dutch Neck Dentals health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, and treatment.

I understand that:

- I do not have to sign this form
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, Dutch Neck Dental may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be re-disclosed and no longer be protected by privacy law.
- Dutch Neck Dental does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell Dutch Neck Dental in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Dutch Neck Dental already sent before receiving my written instructions to stop.

Patient name (please print) _____

Signature _____ Date _____

Dutch Neck Dental

Financial Policy

Our office is committed to providing excellent dental care. We are also concerned with making it affordable for you. Our office has various payment plans, including an in-house Insurance Plan, Care Credit and Citi card, which enable you to benefit from dental procedures immediately, while comfortably managing your resources. We accept Visa, MasterCard, Discover, checks and cash.

We require payment on the day of service for Non-contracted and uninsured patients.

For patients with Delta Dental and MetLife, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement of your treatment. However, if we do not receive payment from your insurance carrier, you will be responsible for any remaining balance.

For patients with any other insurance carrier we are more than happy to electronically summit claims for your prompt direct reimbursement.

If you have any questions, please do not hesitate to ask. We are here to help you get the dental care you want and/ or need.

Appointment Policy

In order to avoid a broken appointment fee of **$25 or more**, please provide our office with a 24 hour notice of any cancelations.

Thank you for choosing Dutch Neck Dental!