EAST SIDE SMILES

PATIENT INTAKE FORMS

Welcome to our practice! Please complete this form as accurately as possible. It is important for us to have this information in order to provide the best possible care for you/your child. Your privacy is important to us. The information you share with us will remain strictly confidential.

PERSONAL INFORMATION

Patient ID #:_____

Patient's Name: _____

☐ Male ☐ Female

Date of Birth: _____/_____/_____

SSN: _____

Mailing Address: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell

Email address: _____

Employer (include address): _____

Occupation: _____

Referred by: _____

In the event of an emergency, who do you want us to contact?

Name:_____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

Name of primary subscriber:

Relationship to patient:

Date of Birth: _____ Social Security No.: _____

Name of Employer: _____ Employer Phone: _____

Insurance Company Name: _____

Member ID: _____ Group #: _____

Ins. Co. Mailing Address: _____

Ins. Co. Phone #: _____

DENTAL HISTORY

(Previous) Dentist:_____ Office Phone #: _____

Date of Last Exam:_____ Last Cleaning:_____ Last X-ray _____

Please check all that apply:

Had previous orthodontic care: ☐Yes ☐No **Name of Orthodontist:** _____

Pain with the teeth, mouth, or jaws: ☐Yes ☐No

Speech Problems: ☐Yes ☐No

Suffered any injuries to teeth or jaw: ☐Yes ☐No

Suck thumb, fingers or pacifier: ☐Yes ☐No

Have any other habits or concern: □Yes □No
If Yes, Please describe: _____
What kind of water does the patient drink? □ City Water □ Well Water □ Bottled Water □ Other:
Has patient ever had complications following dental treatment? □ Yes □ No If Yes, please describe: _____
Does patient have to be pre-medicated with an antibiotic prior to receiving dental care? □ Yes □ No

MEDICAL HISTORY

Physician's Name:
Office Phone #:
Pharmacy:_____ **Phone #:** _____
What do you rate your overall health? □ Excellent □Good □Fair □Poor
Immunization current? □Yes □No

Please check YES or NO to indicate if patient has, has had, or has been diagnosed with any of the following:

AIDS/HIV □Yes □No
Prone to ear infections □Yes □No
Hernia Repair □Yes □No
Asthma □Yes □No
Psychiatric Care □Yes □No
Latex Allergy □Yes □No
Diabetes type □Yes □No
Dizziness or Fainting □Yes □No
Sinus Trouble □Yes □No
Facial/Jaw/TMJ Pain □Yes □No
Nervous Disorders □Yes □No
Heart Condition □Yes □No
Ulcer □Yes □No
Hepatitis Type □Yes □No
Anemia □Yes □No
Prone to sore throats □Yes □No
Kidney Disorder □Yes □No
Bone Disorder □Yes □No
Rheumatic Fever □Yes □No
Seizures □Yes □No
Liver Disorder □Yes □No
Mitral Valve Prolapse □Yes □No
Trauma to face or jaw □Yes □No
Tuberculosis □Yes □No
Cancer □Yes □No
Heart Murmur □Yes □No

Other medical condition not listed above: _____
Medications: _____
Allergies: _____
Has patient ever been hospitalized? □YES □NO If YES, please describe:

FEMALE PATIENTS

Is patient on any type of prescribed birth control? □YES □NO
If YES, please specify:
Is patient pregnant □YES □NO
If YES, what is the due date:
Is patient nursing? □YES □NO

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OFFICE POLICIES

1) **Lateness:** We have a strict **15 minute lateness policy**. If you are more than 15 minutes late we will have to reschedule it if interferes with the following patient's appointment.
2) **No Show Policy**: If you miss an appointment without a 24 hour notification you will be subject to a **$50.00 charge.** This is NOT payable by your insurance and is the sole responsibility of the patient.
3) **Contact Information:** It is the patient's responsibility to notify the office of his/her name, address or contact information change.
4) **Insurance:** As a courtesy to our patients we will verify your insurance coverage at the time of your appointment. **Verification of benefits is NOT a guarantee of payment.** You, as the patient, are responsible to know your deductible, maximum and copayments. We ask that you clarify these questions with your insurance company prior to your visit.
5) **ALL SERVICES MUST BE PAID AT THE TIME OF VISIT.**
6) Any balance over due by 90 days, or after the final dental bill has been sent to the patient, will be submitted to collections.
7) Our office will not enter into a dispute with your insurance company for dental claims if the denial was due to your negligence (ie: policy termination, premium not paid etc...)
8) **We cannot guarantee that your insurance company will pay**. We will make every attempt at the beginning of your dental care to verify your policy and what is and is not covered. In the event that you are denied because your insurance has been terminated or your annual maximum has been met, the patient is responsible for the unpaid balance.

I have read the above information and fully understand my responsibilities as a patient of East Side Smiles dental practice.

_____ _____

Patient/Guardian Signature Date

333 E. 79th Street, Suite 1U, New York, NY 10075

Office: 212-744-5544 Fax: 212-744-5556 | eastsidesmiles333@gmail.com

EAST SIDE SMILES

HIPPA AUTHORIZATION

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.

We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder

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on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.
If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the end of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

I acknowledge that I have read, received and understood East Side Smile's Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____