Patient Health Record

In order for me to render the proper dental services to you, would you please be kind enough to answer the following questions. Please note the space for remarks for any answers that require clarification or any other information you think I should have. Thank you for your cooperation.

DATE

NAME (LAST) (FIRST) (MIDDLE)

ADDRESS

HOME PHONE CELL PHONE E-MAIL ADDRESS

BUSINESS ADDRESS BUSINESS PHONE

DATE OF BIRTH SEX HEIGHT WEIGHT OCCUPATION

MARITAL STATUS (circle) SINGLE MARRIED WIDOWED DIVORCED

SPOUSE'S NAME (PARENT'S NAMES IF MINOR)

TYPE OF DENTAL INSURANCE (if applicable) SOCIAL SECURITY NO. (FOR PARENT IF MINOR)

REFERRED BY MOST CONVENIENT APPOINTMENT TIME

MEDICAL HEALTH

General health (please circle) EXCELLENT GOOD FAIR POOR

Name and address of physician

Last complete physical?

Are you taking medication now? Yes No For what purpose?

Do you have or have you ever been treated for: (please circle)

Heart disease	Yes	No	H.I.V. Infection	Yes	No	**NOTES:**
Rheumatic fever	Yes	No	Heart murmur	Yes	No	
Abnormal blood pressure	Yes	No	Jaundice	Yes	No	
Ulcers	Yes	No	Asthma or hay fever	Yes	No	
Tuberculosis or lung disease	Yes	No	Sinus trouble or cough	Yes	No	
Diabetes	Yes	No	Hepatitis	Yes	No	
Epilepsy	Yes	No	Arthritis	Yes	No	
Anemia	Yes	No	Stroke	Yes	No	
Congenital heart lesions	Yes	No	Glaucoma	Yes	No	

Have you ever been hospitalized? .... Yes No

Are you allergic to: Penicillin Codeine Local injected anesthetics Other medications

Are you subject to prolonged bleeding? .... Yes No

Are you subject to fainting spells? .... Yes No

Do you have excessive urination and/or thirst? .... Yes No

Are you pregnant? (Women) .... Yes No How long?

Over

DENTAL HEALTH

Reason for visit: ______________________________

When was your last dental visit? ______________________________

Have you ever had any serious problem associated with previous dental treatment? .... Yes No

If so, explain: ______________________________

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How often do you brush your teeth? ______________________________

How often do you floss? ______________________________

Do you use an electric toothbrush? Yes No If yes, what type? ______________

Do your gums bleed while brushing? .... Yes No

Do your gums bleed while flossing? .... Yes No

Do you avoid brushing any part of your mouth because of pain? .... Yes No

If yes, what part? ______________________________

Do you feel twinges of pain when your teeth come in contact with:

a) hot foods or liquids, *i.e.,* soup, coffee, tea, etc.? .... Yes No

b) cold foods or liquids, *i.e.,* ice cream, cold fruit, etc.? .... Yes No

c) sweets, *i.e.,* candy, fruit, sweet desserts, etc.? .... Yes No

d) sours, *i.e.,* lemons, limes, grapefruit, etc.? .... Yes No

Do you feel pain to any of your teeth when brushing or flossing them? .... Yes No

Do you chew on only one side of your mouth? .... Yes No

If yes, explain: ______________________________

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Do your gums feel tender or swollen? .... Yes No

Do you clench or grind your jaws while sleeping or during the day? .... Yes No

Do your jaws ever feel tired? .... Yes No

Do you wear dentures? .... Yes No

Do you usually have many cavities? .... Yes No

Do you loose fillings or break fillings? .... Yes No

Do you gag easily? .... Yes No

Are you familiar with the term "preventive dentistry"? .... Yes No

Are you happy with the appearance of your teeth? .... Yes No

Do you smoke? .... Yes No

Please add anything you feel is important: ______________________________

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(Patient signature)

HIPAA Notice of Privacy Practices

Jerome S. Loewenstein D.M.D., P.C., James J. Sullivan D.D.S.

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your dentist, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dentist's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operation: We may use or disclose, as needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, marketing and fund-raising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information during the evaluation of hygiene procedures with staff. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without you authorization. These situations include: as required by law, Public health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Heath and Human services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records ; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of you protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information
not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not requires to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means, or at an alternative location. **You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your dentist amend you protected health information. If we deny your request for amendment, you may have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name:_______________________ Signature:_________________________ Date:________

Precision Arts Dental Associates, PC

100 South Highland Avenue
Ossining, NY 10562

Phone: (914) 941-0825

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT

We now offer the following payment options:

___ Payment by cash

___ Payment by check

___ Payment by credit card

___ Automatic monthly billing to your Visa or MasterCard

___ Guarantee any amount not covered by insurance with Visa or MasterCard

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see the office manager. Thank you.

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Print your name here and sign below

*x*______________________________
*Date:*___________________________

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