Patient Name: _____

North Shore Dental of Huntington

Demographics

Name: _____ I prefer to be called: _____

Gender: _____ Birthdate: ____/____/____ SSN: _____

Home Address: _____

City: _____ State: ____ Postal code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Preferred method of contact: Call/Text/Email _____

Who may we thank for referring you? _____

Responsible Party/Guarantor Information

Is the patient also the guarantor? _____

Guarantor First name: _____ Guarantor Last name: _____
Relationship to patient _____ Phone number_____
Address: _____ City: _____ State: ____ Postal code: _____

Employment Details

Occupation: _____ How long: _____

Employer name: _____

Please list two contact names whom practice can release PHI information (HIPPA)

First name _____ Last name _____

Phone number_____

First name _____ Last name _____

Phone number_____

_____ _____ _____

Patient Name Patient signature Date

Patient Name: _____

North Shore Dental of Huntington

Dental Insurance

Do you have dental insurance? _____

Name of insured: _____ Birthday of Insured ___/____/____

Address of insured: _____

City: _____ State: _____ Postal code: _____

Patients relationship to insured: _____

Insured employer name: _____

Insured employers address: : _____

City: _____ State: _____ Postal code: _____

Primary Insurance:

Insurance company Name: _____ Plan name: _____

Group #_____ Member/Subscriber #_____

Insurance company address: _____

City: _____ State: _____ Postal code: _____

Insurance company phone number _____

Secondary Insurance:

Insurance company Name: _____ Plan name: _____

Group #_____ Member/Subscriber #_____

Insurance company address: _____

City: _____ State: _____ Postal code: _____

Insurance company phone number _____

Patient Name: _____

North Shore Dental of Huntington

Notice: X-rays and Insurance Coverage

We will recommend that certain x-rays be taken on a periodic basis as they may provide important diagnostic information to detect early stages of decay and other oral diseases. Each insurance policy varies on coverage of x-rays, and the x-rays we recommend may not be covered by your insurance policy. We encourage you to know and be aware of the x-ray policy of your insurance carrier. If you should choose to decline having x-rays taken that we recommend for you, please notify us.

_____ _____ _____

Patient Name Patient signature Date

Patient Name: _____

North Shore Dental of Huntington

Photo Consent

I Authorize Dr. Tara Boshnack DDS to take photographs and/or videos of my face, jaws, and teeth, before during and after treatment.

I consent to allow the photographs to be used for the following:

Dental Records

Dental Research

Dental education including lectures, seminars, demonstrations, professional publications such as journals or books

Marketing materials. Including websites and printed materials, patient education.

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise for the use of these photographs.

_____ _____ _____

Patient Name Patient signature Date

Patient Name: _____

North Shore Dental of Huntington

Financial Policy

The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. As consistent with applicable laws and the policies of the patient's applicable dental insurance or other third-party payer coverage, we require the following:

All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

All dental services are charged directly to the patient and the patient is personally responsible for payment of all dental services, even if the patient carries dental insurance. This office will, as a courtesy, help prepare the patient's insurance forms and may assist in making collections from dental insurance companies, and will credit any collections from insurance to the patient's account.

Fee estimates for dental care can only be extended for a period of six months from the date of consultation.

Payment for services is due at the time of treatment.

Charges for services shall be as billed unless objected to, by the patient, in writing, within the time payment is due.

_____ _____ _____

Patient Name Patient signature Date

Patient Name: _____

North Shore Dental of Huntington

HIPPA Privacy Policies & Procedures

Our dental office recognizes our obligation to protect the privacy of health information that we create, receive, maintain, or transmit. We must not use or disclose protected health information except as permitted by these policies and procedures. We will make a good faith effort to obtain a written Acknowledgement of Receipt of our notice of privacy practices as well as consent for use and disclosure of health information form from a patient prior to treatment, obtaining payment for that treatment, or for our routine operations. Our use or disclosure of PHI for reimbursement of services and healthcare operations may be subject to the minimum necessary requirements. Our dental office will become familiar with New York privacy laws. We will ask our patients to sign a Consent for treatment form prior to treatment unless an emergency situation or communication barriers precludes us from doing so. We will keep the signed consent for treatment form, the acknowledgement of receipt of our notice of privacy practices form, and consent for use and disclosure of health information in the patient char.t If a patient wants to evoke the consent he may do so by giving us written notice. This will also be kept in the patients chart.

Authorization:

We must have written authorization form the patient (or his personal representative) before we use or disclose a patient's PHI for any purpose beside TPO. We routinely use the authorization form and act in accordance with it. A patient may receive his authorization at any time by written order. Our practice may use professional judgement and our experience with common practice to make reasonable inferences of the patients' best interest allowing a person to act on behalf of the patient when picking up dental/medical supplies, x rays records or other forms of PHI. Our office may use or discloses patients pHI in certain situations without authorization or Oral agreement. These instances include:

These instances include:

- Public health activities
- For heath oversight agencies
- To coroners, medical examiners, funeral directors
- To employers regarding worker's compensation illness or injuries
- To the military
- To federal officials as needed for intelligence, counter intelligence, or national swcurity
- To correctional facilities regarding inmates
- In response to subpoenas/other judicial processes
- To law enforcement officials
- To report abuse, neglect, or domestic violence
- If required by law
- As part of research projects
- To the US department of health and human services on request for complaint investigations or concerns about our compliance

We will always document the disclosure of PHI on our disclosure log. We will also ensure that the officials to whom we are releasing the information have appropriate identification such as government issued ID badge, drivers license. We will not release PHI to a personal representative if we are the reason to believe it may endanger the patient or expose them to further abuse. We will not disclose PHI to a third party for their

marketing purposes. We will disclose PHI to a patient or to his personal representative to the extent that the patient has a right of access to it. We will disclose on the minimum necessary to accomplish the request. However, this is not necessary within our practice or when requested by another healthcare provider providing our patient treatment If there is a non0routine request for the disclosure of PHI, no release will be made until reviewed b the privacy officer to ensure that only the minimum necessary information will be disclosed. Our office will not disclose, or request an entire record of a patient unless a specific situation requires us to do so.

Business associates:

Our dental office will obtain business agreements as specified by the federal government after April 1, 2993 that will indicate there responsibility for our patient's PHI. This agreement will outline how they may disclose pHI and safeguard this information. If we discover that they have violated the privacy provisions of this agreement we will take immediate steps to make sure the violations stop or it will become necessary to terminate the contract with that associate. If it is not feasible to terminate the contract, we will notify the US department of HHS.

Amending patient records

Patients now have the right to request amendments to their PHI and other records as long s our office keeps patient records. We may deny the request to amend the records if we did not create the information (unless the patient has a reasonable basis to believe the originator of the original data is not available on request to amend, if the information si accurate and complete as written, or if we do not have the information. By amending the record, we will not physically delete or change existing information on a chart. We will amend the record by noting the changes on the next line of entity on the patient chart and date it, we will notify our business associates who may need information on the amendment. We will also contact other entities or individuals who may have received information form us who may have acted upon the information in a manner, which is detrimental to the patient. If we deny the request for amendment, we will mark any future disclosures of the contested information in a way that acknowledges the context. Patients also have a right to review whom we made disclosures of their PHI for other reasons other than treatment, payment, or healthcare operations or the previous six years, nut not before April 14, 2003. Each entry of disclosure will be noted in the patient chart with the following information: date of disclosure to whom including names and addresses, for what purpose. We are not legally required to record disclosures when done to the patient representative for anything related to treatment, payment or operations for any legal, law enforcement, governmental purposes, or in response to a patient authorization, if requested to do so by a governmental agency we will temporarily suspend the accounting of disclosures. We will charge a fee for any accounting requested that is more frequent than one per year. The patient must be informed of this fee before the accounting is provided. We will also contact our business accounting any disclosures made by them which we must account. Patients may request that we restrict our use fo their PHI including for reasons of treatment. We have no obligation to honor that request, but if we tell the patient we will, we must honor request unless precluded by a medical emergency. If honored we must notify our business associates that may be involved of the patient request. This will be documented in the patient chart as well. patients have the right to we contact them via alternative means or locations when discussing PHI. We will accommodate ht epatient request if is reasonable and done in writing. If we comply with the request we also notify our business associates of the agreement and give them alternate information.

Staff training and management:

Patient Name: _____

North Shore Dental of Huntington

We will be training our staff regarding our privacy policies and procedures so they may caryr out the duties appropriately This will eb done prior to April 14 2003. After that date new staff members wil be trained within reasonable time after the person begins employment If there is a material change in our practices, we will retrain all staff members within a reasonable time after that change. We will ask all staff members to sign the staff review of policies and procedures form to document their training and receipt of the policy If s astaff member violates our privacy policies or other federal or state laws he will be subject to disciplinary action up to and including suspension without pay or termination fo employment.

Complaints:

The complain form will be given to a patient who believes his privacy rights have been violated. We will investigate all complaints and attempt to resolve said complaints. Each complain will be given to the privacy officer immediately for resolution. We are required to not retaliate against any patient who in good faith has lodged a complaint.

Payment or healthcare operation

Safeguards:

Our dental practice will hoor these privacy policies and procedures within our daily operations by taking reasonable steps to ensure that incidental uses and disclosures of PHI will be avoided. While it is impossible in the practice environment to completely limit the possibility of overheard conversations among staff regarding patients, we will not use any information as such as patients full name that may identify a patient. We will be discreet when asking of patient, calling in patients prescriptions where it may be overheard by others using low voices. Employees will be given computer passwords and will be limited to computer access to the information necessary for htem to carry out his/her duties. These policies and procedures are effective August 10, 2015 and may only be changed but eh owner of the practice, Dr Tara Boshnack. We recognize that we must comply with all New York laws that have jurisdiction over our practice. We also recognize we must give the US department of health and human services access to our facilities, records, charts, accounts that include individually identifiable PHI without patient authorization or notice during normal business hours. We will cooperate with any compliance review or complaint investigated by HHS wile preserve the rights of our practice.

_____ _____ _____

Patient Name Patient Signature Date

Patient Name: _____

North Shore Dental of Huntington

Dental History

Is Patient a Minor: Y/N If Yes, is this your child's first Dental visit Y/N

Do you/ your child have any of the following?

Cavities/decay	YES	NO
Lip Sucking/ Biting	YES	NO
Speech Problems	YES	NO
Nail Biting	YES	NO
Pacifier/thumb/finger sucking	YES	NO
Mouth breathing	YES	NO
Tongue thrust	YES	NO
Nursing/Bottle habits	YES	NO
Jaw Problems		NO
Have you ever had orthodontic treatment (braces)?	YES	NO
Have you ever had any pain/tenderness In their jaw joint (TMJ/TMD)	YES	NO

Reason for visit: _____

Date of last dental visit: _____ Date of last dental x-rays _____

How often do you floss? _____ How often do you brush? _____

Bad Breath	YES	NO
Bleeding, swollen, red gums	YES	NO
Broken/loose fillings or teeth	YES	NO
Clicking or popping jaw	YES	NO
Grinding teeth	YES	NO
Pain around ear/side of face	YES	NO
Sores blisters in the mouth	YES	NO

List any other dental concerns/pain_____

What did you like the most about your previous dental office? _____

What did you like the least about your previous dental office? _____

Are you interested in whitening your smile? _____

Are you happy with your smile? _____

If not, what would you change? _____

Patient Name: _____

North Shore Dental of Huntington

Medical History

Allergy: Aspirin	YES	NO
Allergy: Codeine	YES	NO
Allergy: Latex	YES	NO
Allergy: Local Anesthesia	YES	NO
Allergy Penicillin:	YES	NO
Allergy: Sulfa	YES	NO
List any other allergies:	_____	
Abnormal Blood pressure	YES	NO
AIDS/HIV	YES	NO
Artificial heart valves	YES	NO
Blood disease	YES	NO
Congenital heart lesions	YES	NO
Heart problems	YES	NO
Pacemaker	YES	NO
Arthritis/Rheumatism/Gout	YES	NO
Artificial Joints/Bones	YES	NO
Asthma	YES	NO
Cancer	YES	NO
Chemotherapy	YES	NO
Diabetes	YES	NO
Emphysema	YES	NO
Glaucoma	YES	NO
Radiation treatment (Xray/cobalt)	YES	NO
Shortness of breath (breathing problems)	YES	NO
Sinus trouble	YES	NO
Stroke	YES	NO
Thyroid problems	YES	NO
Tuberculosis	YES	NO
Tumor/Growth on head/neck	YES	NO
Ulcer	YES	NO
Epilepsy	YES	NO
Fainting/Dizzy	YES	NO
Headaches	YES	NO
hepatitis	YES	NO
Herpes	YES	NO
Kidney disease	YES	NO
Liver disease	YES	NO
Nervous Problems	YES	NO
Psychiatric Care	YES	NO

Patient Name: _____

North Shore Dental of Huntington

Please explain any yes answers: _____

List any other medical issues you have: _____

List any serious illnesses/surgeries/hospitalizations: _____

Have you ever taken fosomax or any bisphosphonates? _____

Are you taking any medications? _____ (Yes or No)

List ALL medications you are taking:

_____

_____

Do you smoke?	YES	NO
Do you drink alcohol	YES	NO
Do you use recreational drugs?	YES	NO
Do you have a high sugar intake?	YES	NO

Are you pregnant?	YES	NO	Maybe
Are you nursing?	YES	NO	
Are you under care of physician?	YES	NO	

Physician Name: _____

Physician Phone number: _____

State reason for hospitalization: _____

Is patient physically mentally, emotionally impaired? _____

Describe the patient's current physical health: Excellent, Good, Fair, Poor_____

_____ _____ _____

Patient Name Patient signature Date