



**HIPAA CONSENT FOR USE AND DISCLOSURE OF
HEALTH INFORMATION**

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____ ZIP: _____

Telephone: _____ Email: _____

Social Security Number: _____

**SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS
CAREFULLY**

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Lisa Bauer

Telephone: 845-565-6677 | **Fax:** 845-565-6163 | **Email:** info@windsordental.com

Address: Windsor Dental Center, 375 Windsor Highway, Suite 400, New Windsor, NY 12553

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if revoke this Consent.

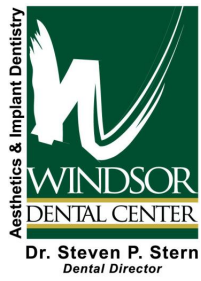
I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care options.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____



NEW PATIENT INFORMATION FORM

NAME: (Last, First, Middle): _____ TITLE: _____

PREFERRED NAME: _____ SS #: _____ DOB: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (____)____-_____ MARITAL: _____

WORK PHONE: (____)____-_____ SEX: _____

CELL PHONE: (____)____-_____ EMAIL: _____@_____

How would you prefer we contact you to confirm your appointments?

PRIMARY DENTAL INSURANCE COVERAGE

INSURED'S NAME: _____ RELATION TO PATIENT _____

INSURED'S SS #: _____ DOB: _____

EMPLOYER: _____

INSURANCE PLAN: _____ GROUP # _____

INSURANCE ADDRESS: _____

SECONDARY DENTAL INSURANCE COVERAGE

INSURED'S NAME: _____ RELATION TO PATIENT _____

INSURED'S SS #: _____ DOB: _____

EMPLOYER: _____

INSURANCE PLAN: _____ GROUP # _____

INSURANCE ADDRESS: _____

RESPONSIBLE PARTY FOR THE ACCOUNT

I understand that I am financially responsible for any deductibles, co-insurance, and/or any other service not paid or covered by my insurance company.

NAME: _____

ADDRESS: _____

SIGNATURE: _____ DATE: _____

How were you referred to our office? _____



MEDICAL HISTORY

NAME: _____ DOB: _____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate to your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

DENTAL

1. Are you having any discomfort at this time?.....YES ___ NO ___
2. Have you ever had any serious trouble associated with previous dental treatment?.YES ___ NO ___
If yes, please explain _____
3. Does dental treatment make you nervous? No ___ Slightly ___ Moderately ___ Extremely ___
4. When was your last dental cleaning? _____
5. Have you ever been treated for periodontal disease (gum disease, trench mouth)?..YES ___ NO ___
6. How often do you brush your teeth? _____
Brush type: Soft Medium Hard Electronic
7. Do you use any of the following?
Floss Fluoride Rinse Other
8. Do you have or have had any of the following?

MOUTH

- | | | |
|--------------------------------|-----|----|
| Bleeding / Sore gums | YES | NO |
| Unpleasant / Bad Breath | YES | NO |
| Swelling / Lumps in Mouth | YES | NO |
| Ortho Treatment (braces) | YES | NO |
| Clicking / Popping jaw | YES | NO |
| Difficulty opening/closing jaw | YES | NO |
| Frequent blisters, lip/mouth | YES | NO |

TEETH

- | | | |
|----------------------|-----|----|
| Loose Teeth | YES | NO |
| Sensitive to Hot | YES | NO |
| Sensitive to Cold | YES | NO |
| Clenching / Grinding | YES | NO |
| Shifting in Bite | YES | NO |
| Change in Bite | YES | NO |

MEDICAL

1. Has there been any change in your health within the last year?.....YES NO
2. My last physical examination was on _____
3. Are you now under the care of a physician?.....YES NO
If yes, explain _____
4. The name and address of my primary physician is: _____
5. Have you had any serious illness within the past 5 years?.....YES NO
If so, explain _____
6. Have you been hospitalized or had an operation within the past 5 years?.....YES NO
If so, explain _____
7. Do you have or have you had any of the following disease or problems?
 - a. Heart Murmur, rheumatic fever, or rheumatic heart disease?.....YES NO
 - b. Mitral valve prolapse?.....YES NO
 - c. Cardiovascular disease?.....YES NO
 - d. High / Low Blood pressure?.....YES NO
 - e. Artificial or replacement valves?.....YES NO
 - f. Pacemaker?.....YES NO
 - g. Sinus Trouble?.....YES NO
 - h. Asthma or hay fever?.....YES NO
 - i. Fainting spells?.....YES NO
 - j. Diabetes Type I or Type II?.....YES NO
 - k. Hepatitis, jaundice or liver disease?.....YES NO
 - l. Arthritis or inflammatory rheumatism?.....YES NO
 - m. Artificial or replacement joints?.....YES NO
 - n. Digestive disorders (ulcers or stomach disorders)?.....YES NO
 - o. Kidney trouble?.....YES NO



- p. Tuberculosis?.....YES NO
- q. Immune System Disorders (including AIDS, HIV, ARC)?..... YES NO
- r. Venereal Disease?..... YES NO
- s. Other?..... YES NO
8. Have you had abnormal bleeding with previous extractions, surgery, etc?..... YES NO
- a. Do you bruise easily?.....YES NO
- b. Have you ever had a blood transfusion?.....YES NO
- If so, explain circumstances and when? _____
9. Do you have a blood disorder such as anemia?.....YES NO
10. Have you had surgery or x-ray treatment for a tumor, growth, or condition?.....YES NO
11. Are you taking any of the following?
- a. Antibiotics or sulfa drugs?.....YES NO
- b. Anticoagulants (blood thinners)?.....YES NO
- c. Medicine for High blood pressure?.....YES NO
- d. Cortisone?.....YES NO
- e. Tranquilizers?..... YES NO
- f. Antihistamines?.....YES NO
- g. Aspirin?..... YES NO
- h. Insulin, tolutamide (Orinase) or similar drug for diabetes?.....YES NO
- i. Digitalis or drugs for heart trouble?.....YES NO
- j. Nitroglycerin?..... YES NO
- k. Other medications?.....YES NO
- If yes, please describe _____
13. Are you allergic or have you reacted adversely 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? _____
14. Do you use any tobacco products?.....YES NO
- If so, what and how much per day? _____
15. Do you use any alcohol products?..... YES NO
- If so, how much per day / week / month and what? _____
16. Do you use any caffeinated products (coffee, tea, chocolate, etc.).....YES NO
- If so, how much per day and what? _____
17. Do you have any disease, condition, or problem not listed above?.....YES NO
- _____
18. Are you employed in any situation which exposes you regularly to x-rays or other radiation?.....YES NO

WOMEN

21. Are you pregnant?.....YES NO
22. Are you taking birth control or hormone therapy.....YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient/Guardian Date

Signature of Dentist Date



OFFICE GUIDELINES

If you have dental insurance we will gladly process your claim but we request that you pay your *estimated* out of pocket when services are rendered.

If you do not have insurance, payment is expected at the time services are rendered, unless prior financial arrangements have been made.

There is a \$75.00 cancellation fee for all appointments with specialists, not cancelled at least 48 hours in advance and all appointments that are 1 hour or longer.

There is a \$50.00 cancellation fee for all appointments with hygiene and general dentists, not cancelled at least 24 hours in advance.

I have read and understand the office guidelines of Windsor Dental Center as stated above.

Signature: _____ *Date:* _____