42 Broadway, Suite 1515
New York, NY 10004
212.269.6655
info@ddsgroupnyc.com

For Your Dental Health Care and Our Efficiency of Diagnosis and Treatment, Please Fill in the Following Confidential Forms Completely. Please Answer All Questions.

**PATIENT**

NAME ______________________________ BIRTHDAY ____________________
LAST FIRST INITIAL MO. DAY YR.

ADDRESS ______________________________ PHONE ____________________
STREET/BOX NO. CITY STATE/ZIP

E-MAIL ______________________________ CELL ____________________

PARENTS NAME (IF CHILD) ______________________________ MARITAL STATUS ____________________

SOCIAL SECURITY NUMBER ______________ DRIVERS LICENSE NUMBER ______________ STATE ________

**RESPONSIBLE PARTY**

NAME ______________________________ RELATIONSHIP ____________________
LAST FIRST INITIAL

ADDRESS ______________________________ PHONE ____________________
STREET/BOX NO. CITY STATE/ZIP

**EMPLOYER(S)**

PATIENT EMPLOYED BY ______________________________
NAME

ADDRESS ______________________________ PHONE ____________________
STREET/BOX NO. CITY STATE/ZIP

SPOUSE NAME ______________________________ DOB ____________________
MO. DAY YR.

SPOUSE EMPLOYED BY ______________________________
NAME

ADDRESS ______________________________ PHONE ____________________
STREET/BOX NO. CITY STATE/ZIP

**EMERGENCY CONTACT**

NAME ______________________________ RELATIONSHIP ____________________
LAST FIRST INITIAL

ADDRESS ______________________________ PHONE ____________________
STREET/BOX NO. CITY STATE/ZIP

**REFERRED BY**

NAME ______________________________ RELATIONSHIP ____________________
LAST FIRST INITIAL

ADDRESS ______________________________ PHONE ____________________
STREET/BOX NO. CITY STATE/ZIP

**INSURANCE**

INSURANCE COMPANY ______________________________ GROUP # ____________________

SPOUSE'S INSURANCE COMPANY ______________________________ GROUP # ____________________

**PHYSICIAN**

NAME ______________________________ PHONE ____________________

How is your general Health: Excellent Good Fair Poor Date of Last Physical Exam _______________________

Have you ever had any of the following? (Check boxes that apply):

- [ ] Heart Murmur
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Circulatory Problems
- [ ] Nervous Problems
- [ ] Radiation Treatment
- [ ] Artificial Heart Valves or Joints
- [ ] Recent Weight Loss
- [ ] Back Problems
- [ ] Diabetes
- [ ] Respiratory Disease
- [ ] Epilepsy
- [ ] Headaches
- [ ] Hepatitis, Jaundice, or Liver Disease
- [ ] Cancer
- [ ] Psychiatric Care
- [ ] Mitral Valve Prolapse
- [ ] Allergies to Anesthetics
- [ ] Allergies to Medicine or Drugs
- [ ] General Allergies
- [ ] Blood Disease
- [ ] Arthritis
- [ ] Special Diet
- [ ] Swollen Neck Glands
- [ ] Rheumatic Fever
- [ ] Sinus Problems
- [ ] AIDS/HIV
- [ ] Thyroid Disease
- [ ] Stroke
- [ ] Ulcer
- [ ] Venereal Disease
- [ ] Chemical Dependency
- [ ] Hemophilia

Are you currently taking any other type of medication __________________________________________ Birth Control Pills ___________________

For what purpose ______________________________________________________________________________________________

Have you had any serious illness or operation in the last 5 years ____________________________________________________________

__________________________________________________________________________________________ Are you Pregnant __________________

Please describe any current medical treatment, impending operations, or any other medical or dental information that you feel I should know about

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

Due to the increased cost of mailing statements and in trying to keep our fees as fair as possible, we expect our patients to pay for services at the time they are rendered, unless arrangements have been made with our financial administrator. We want to give you the best and most reasonable service possible without having to raise our fees. We appreciate your cooperation in this matter.

**SHOULD IT BE NECESSARY FOR YOU TO RESCHEDULE AN APPOINTMENT, WE REQUIRE 24 HOURS NOTICE. IF THE REQUIRED NOTICE IS NOT GIVEN, A FEE WILL BE CHARGED.**

**PLEASE NOTE:** Insurance assignment is a service we provide for your convenience. You are responsible for any charges not covered by your insurance company.

**I FULLY UNDERSTAND AND AGREE TO THE ABOVE POLICY**

**PATIENT SIGNATURE** ________________________________________________ **DATE** ____________________________________

# A Word To Our Patients

Just a friendly reminder regarding the **DDS Group Policy…**

We ask that you make every effort to keep your scheduled appointments. **If you need to reschedule an appointment, we ask that you give our office at least a 24-hour notice.**

Please understand that when you cancel without giving us a 24-hour notice, three people are affected:

You – you do not receive your prescribed treatment
The doctor and/or hygienist – they now have an opening in their schedule where another patient who needed care could have received it
Another patient – who could have received treatment if a 24-hour advance notice had been given by you to our office

**It is your responsibility as a patient to keep your scheduled appointments. We ask that you please give us 24-hour notice if you need to delay your treatment.**

**Notice:** There is a $50 per hour charge for a cancellation that is made without proper notification.

**Important Notice:** I agree that if it is necessary for this office to take legal action to obtain payment for services that were rendered to me, I will be responsible for late fees, collection fees and all attorney fees associated with the collection of outstanding money due and payable to this office.

Thank you.

**Signature** ____________________________________ **Date**__________________________

# 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 this information carefully.

## 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 took effect on April 14, 2003 and will remain in effect until we replace it. We deserve the right to change our privacy practices and the terms of this notice at any time, providing such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant changes in our privacy practices, we will change this notice and make a new notice available to our patients.

You may request a copy of our notice at any time. For more information concerning our privacy practices, or for additional copies of this notice, please contact us using the information provided at the end of this notice.

## Uses and Disclosures of Health Information:

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

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

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

Healthcare Operations: We may use and disclose your information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, review the competence or qualifications of your healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditations, certification, licensing and credentialing activities.

Your Authorization: In addition to our use of your health for treatment, payment, and health operations, you may give us a 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 written authorization, we cannot use or disclose your health information for any reason except for 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 any other person to the extent necessary to help with your health care, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying your location), a family member or your personal representative (another person responsible for your care) of your location, general condition, and/or health. If you are present, prior to use or disclosure of your health information, we will provide you with the opportunity to object to such uses or disclosures. In the event of your incapacity of emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable interferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health- Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authority 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 officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminder: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, post cards, letters, or emails).

## Patient Rights:

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information provided at the end of this notice. We will charge you a reasonable cost-based fee for expenses (such as copies and staff time). You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $0.75 for each page, $20 per hour for staff time to locate and copy your health information and postage if you request to have the information mailed to you. If you request an alternative format, we will prepare a summary or an explanation of your health information for a fee. Please contact us per the information provided at the end of this notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates your disclosed health information for purposes other than treatment, payment, healthcare operations, and certain further activities for the last 6 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate you health information with you by alternative locations (please make your request in writing). Your request must specify the alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendments: You have the right to request that we amend your health information (your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Needs: If you receive this notice on our website or by e-mail, you are entitled to receive this notice in written form.

## Questions and Complaints:

If you would like more information about our privacy practices, or if you have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, you disagree with a decision we made about access to your health information, if you disagree to a response for a request you made to amend or restrict the use of disclosure of your health information, or if you would like to have us communicate with you by alternative means or locations, you may contact us using the contact information listed at the end of this notice.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with this department upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Lee Alves
Telephone: 212.269.6655. ext. #: 308
Fax: 212.269.2247
Email: info@ddsgroupnyc.com
Address: 42 Broadway Suite 1515
New York, NY 10004

# 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 Practice.

Please Print Name_______________________________________________

Signature_______________________________________________________

Date__________________________________________________________

E-Mail_________________________________________________________

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**For Official Use Only**

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We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign

__ Communication barriers prohibited obtaining the acknowledgement

__ An emergency situation prevented us from obtaining acknowledgement

__ Other (Please Specify)

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________