

WELCOME

Stony Point Dental, PC

The benefits of good oral health are immeasurable. It is the goal of the entire team of Stony Point Dental to create a comfortable, relaxing, state of the art environment in which we can help you attain and maintain optimal oral health. Please fill this form out completely, so we may better get to know you. With good communication, we can give you the best possible care.

Patient's Name _____

I prefer to be called _____ ☐ male ☐ female

Address _____

City _____ State _____ zip _____

Birth date ____/____/____ Age: ____ SS# _____

Home # _____ Work # _____

Cell # _____ email _____

Employer _____

Employer Address _____

City _____ State _____ zip _____

Occupation _____

Best time/place to reach you _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous Dentist _____

Date of Last Visit _____

Spouse's Name _____

Employer _____

Work # _____ SS# _____

Birth date ____/____/____ Driver's License # _____

Person Responsible for Account _____

Billing address _____

City _____ State _____ zip _____

Work # _____ cell # _____ SS# _____

Relationship _____

Employer _____

Insurance Information

Dental Insurance: ☐ Yes ☐ No

Primary Ins. Co. Name _____

Address _____

Phone # _____

Group, Plan or Policy # _____

Insured's name _____ Relation _____

Insured's Birth date ____/____/____ ID # _____

Insured's Employer _____

Secondary Ins. Co. Name _____

Address _____

Phone # _____

Group, Plan or Policy # _____

Insured's name _____ Relation _____

Insured's Birth date ____/____/____ ID # _____

Insured's Employer _____

Emergency Contact: name _____

Work # _____ home # _____

Relation: _____

Signature _____

Date _____

Stony Point Dental, PC

Medical History

Do you have a personal physician? ☐ YES ☐ NO

Physician's Name _____

Physician's Phone # _____

Date of Last Visit _____

Are you currently under the care of a physician?

☐ YES ☐ NO

If yes, please explain: _____

Please list any prescription, over-the-counter or herbal supplement drugs you are taking: _____

Have you ever taken **Fosamax**, or any bisphosphonate?

☐ YES ☐ NO

Have you ever taken Phen-fen? ☐ YES ☐ NO

For Women: Are you using a prescribed method of birth control? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO Week # _____

Are you nursing? ☐ YES ☐ NO

Have you ever had any of the following medical conditions?

Y N Abnormal Bleeding	Y N Hepatitis
Y N Alcohol/Drug Abuse	Y N Herpes / Fever Blisters
Y N Anemia	Y N High Blood Pressure
Y N Arthritis	Y N HIV /AIDS
Y N Artificial Bones/Joints	Y N Kidney Problems
Y N Blood Transfusion	Y N Liver Disease
Y N Cancer/Chemotherapy	Y N Low Blood Pressure
Y N Colitis	Y N Pacemaker
Y N Congen. Heart Defect	Y N Psychiatric Problems
Y N Diabetes	Y N Radiation Treatment
Y N Difficulty Breathing	Y N Seizures
Y N Emphysema	Y N Shingles
Y N Fainting	Y N Sickle Cell Disease
Y N Freq. Headaches	Y N Sinus Problems
Y N Glaucoma	Y N Stroke
Y N Hay Fever	Y N Thyroid Problems
Y N Heart Attack	Y N Tuberculosis
Y N Heart Surgery	Y N Ulcers
Y N Hemophilia	Y N Venereal Disease
Y N Heart Valve Replacement	
Y N Infectious Endocarditis	

Please list any medical condition(s) you have ever had:

Are you allergic to any of the following drugs or materials?

Y N Aspirin	Y N Jewelry or metals
Y N Codeine	Y N Latex
Y N Dental Anesthetics	Y N Penicillin
Y N Erythromycin	Y N Tetracycline

Please list any other drugs or materials that you are allergic to: _____

Dental History

How would you rate your current dental health?

☐ Good ☐ Fair ☐ Poor

Are you currently experiencing any discomfort or pain?

☐ YES ☐ NO

Do you have pain or discomfort in your jaw joint (TMJ)?

☐ YES ☐ NO

Do your gums bleed?

☐ YES ☐ NO

Do you like your smile?

☐ YES ☐ NO

Are you interested in tooth whitening?

☐ YES ☐ NO

How many times/week do you floss? _____

How many times/day do you brush? _____

What type of toothbrush do you use?

☐ Soft ☐ Medium ☐ Hard

Do you smoke or use any tobacco products?

☐ YES ☐ NO

Do you have any specific concerns you wish to discuss today? _____

I understand that the information I have given today is accurate to the best of my knowledge, and will be held in strictest confidence. I will inform this office of any changes in medical status. I authorize the dental staff to perform any necessary diagnostic or treatment services with my informed consent.

Signature _____

date _____

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STONY POINT DENTAL, PC - NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Robert S. Chorney, DDS - Compliance Officer
Stony Point Dental, PC
32 S. Liberty Drive
Stony Point, NY 10980
845-942-1600

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

Stony Point Dental, PC
**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

You May Refuse To Sign This Acknowledgement

I have received a copy of Stony Point Dental, PC's Notice of Privacy Practices.

(Please Print Name)

(Signature)

(Date)

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)



Financial Considerations

Stony Point Dental, PC
32 S. Liberty Drive
Stony Point, NY 10980 (845) 942-1600

Place patient label here

- Payment is expected at the time services are rendered. We accept cash, personal check, money order, Visa, MasterCard, American Express and Discover. Financing can also be arranged through *Care Credit*. If your dental needs require multiple visits, convenient payments plans are available.
- As a courtesy, we can submit your insurance claims under most circumstances. If we can verify that coverage is active and that your carrier will assign us benefits directly, we will process and submit your insurance claims. However, all co-payments and deductibles **must** be paid at the time of service. We will wait a maximum of 60 days for the insurance payment. (Insurance is typically paid within 30 days.) After the 60 day waiting limit, we will delete the claim and you will be responsible for payment. We will notify you regarding the balance. If and when the insurance check is received, we will either refund you the balance, or you may elect to leave the credit on account.
- If you do not have dental insurance, or if your insurance carrier will not assign us benefits, payment will be due in full at the time of service. If needed, you will be provided with an attending doctor's statement (ADS). Simply attach it to your signed insurance claim form and send it in for direct reimbursement to you.
- If you have any questions or concerns regarding fees or any other issues, please feel free to discuss them with us.

I have read and understand the financial policies set forth above. I understand that a finance charge may be applied to unpaid balances over 60 days, computed by a periodical rate of 1.5% monthly, (18% ANNUALLY), and I am responsible for any legal and collection fees.

Print Name

SIGNATURE

DATE