FLORHAM PARK DENTAL EXCELLENCE
VINEET V. SOHONI, D.D.S.
ADRIENNE AMIRATA, D.M.D
Cosmetic and Reconstructive Dentistry
Master in the Academy of General Dentistry
140 Columbia Turnpike , NJ 07932 • Phone 973-377-4212 • FAX 973-377-8214

Patient Information

Patient Name _____ Date_____
Last First Middle
☐ Married ☐ Single ☐ Child ☐ Other If child, parent's name_____
Social Security # _____ Birth Date _____ ☐ Male ☐ Female
Phone (Home) _____ (Work) _____ Ext ____ (Cell) _____
(E-mail) _____Best time to call _____ Preferred # to call
Preferred appointment times ☐ Morning ☐ Afternoon ☐ Any Time ☐M ☐Tu ☐W ☐Th ☐F ☐Sa

Address_____
Street Apartment #
_____
City State Zip Code

Spouse's Name:_____ Cell Phone:_____

Social Security#:_____ Date of Birth:_____

Nearest relative not living with you:_____ Phone:_____

Please indicate name of person or entity referring you to our practice_____

Health Information

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Allergies to Medication
_____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Chemotherapy
☐ Chemical Dependency
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tobacco Habit
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
☐ _____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain_____
- Primary Physician: _____ Phone:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain_____
- Are you taking any drugs or medications? ☐ Yes ☐ No
  If yes, please list _____

_____

Women Only:

Are you Pregnant? ☐YES ☐NO Are you Nursing? ☐YES ☐NO

Emergency Contact Information:

Name _____ Phone _____ Relationship _____

Employment Information

Employer Name _____ Occupation _____

Address _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date _____ ID # _____ Group #_____

Insured's Address_____
Street City State Zip

Insured's Employer Name_____

Address _____
Street City State Zip

Patient's relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address _____

Secondary

Name of Insured _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date _____ ID # _____ Group #_____

Insured's Address_____
Street City State Zip

Insured's Employer Name_____

Address _____
Street City State Zip

Patient's relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address_____

Medical Insurance

Name of Insured _____
Last First MI

Insured's Birth Date _____ ID # _____ Group #_____

Insured's Employer Name_____

Address _____
Street City State Zip

Patient's relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address_____

Dental Health Information

Previous Dentist:_____ Phone#:_____

Date of last dental visit _____Reason for that visit _____

_____

- Do you have any current dental problems? ☐ Yes ☐ No
  If yes, please describe _____

_____

- Do you experience pain with heat, cold, sweets or while biting or chewing? ☐ Yes ☐ No
  If yes, please describe _____
- How often do you brush your teeth? _____ Vigorously or Lightly _____
- How frequently do you floss? _____ Do you use aides to clean your teeth? ☐ Yes ☐ No
  If yes, please circle which ones: Electric Toothbrush – Rubber Tip Stimulator - Floss Threader
  Proxabrush - Fluoride Gels - Other_____
- How often do you have your teeth professionally cleaned? _____
  Have you ever had professional instruction in taking care of your teeth? ☐ Yes ☐ No
- Do your gums bleed when brushing? ☐ Yes ☐ No
- Do your gums feel irritated, tender or swollen? ☐ Yes ☐ No
- Do you have a recurrent unpleasant taste or breath (particularly on arising)? ☐ Yes ☐ No
- Have you ever been informed that you have periodontal disease? ☐ Yes ☐ No
- Have you ever had periodontal surgery? If yes, when and what area(s) of our mouth? ☐ Yes ☐ No
- Have you ever had deep scaling and planning of the root surfaces of your teeth? ☐ Yes ☐ No
- Are you aware of clenching your teeth during the day? ☐ Yes ☐ No
- Are you aware of clenching or grinding your teeth while you sleep? ☐ Yes ☐ No
- Do you ever experience aches or pains in the sides of your face close to your ears? ☐ Yes ☐ No
- Are you subject to chronic headaches? ☐ Yes ☐ No
- Do you have chronic neck or shoulder pains? ☐ Yes ☐ No
- Have you ever noticed a clicking, cracking or popping sound near your ears? ☐ Yes ☐ No
- Do you ever experience a burning sensation of the tongue? ☐ Yes ☐ No
- Do you chew on both sides of your mouth? ☐ Yes ☐ No
- Do you have any missing teeth? ☐ Yes ☐ No
- Do you wear full dentures or partial dentures? ☐ Yes ☐ No
  If yes, how long have you had them? _____
- Have you had dental implants? If yes, how long have you had them? _____ ☐ Yes ☐ No

- If you don't have replacements for your missing teeth, have you considered any options? ☐ Yes ☐ No
  If so, what options?_____
- Please circle which of the following pain control aides you have had in the past
  Local anesthetic Nitrous oxide Sodium pentothal
- Do you have any fear of having dental work? ☐ Yes ☐ No
- Have you ever had a traumatic dental experience? ☐ Yes ☐ No
  If yes, please explain _____

  _____
- If you could change anything about the dental experience, what would that be?
  _____
- Are you happy with the appearance of your smile? ☐ Yes ☐ No
- What would you like to change about your smile? _____

  _____
- Would you like to know more about the different cosmetic solutions that are available to improve your smile (e.g.: laminates, crowns, whitening, etc.) ☐ Yes ☐ No

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Payment options are cash, check, credit card and dental credit card. All dental services must be paid for at the time services are performed.

Patients who enjoy the benefits of insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all these services. This office will provide proof of dental services performed for submission by the patient to his/her insurance carrier for reimbursement.

In the rare instance of an outstanding balance, a service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care will be valid for a period of six months from the date of the patient examination.

I grant my permission to you or your staff to:

	Yes	No
Telephone me at **home** to discuss matters related to this form, my treatment and/or related appointments	___	___
Telephone me at **work** to discuss matters related to this form, my treatment and/or related appointments	___	___
Leave a message for me on my answering machine at home	___	___
Leave a message for me on my answering machine at work	___	___
Mail reminder cards to me at home	___	___

I have read the above conditions of treatment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

_____
Signature of patient, parent or guardian

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the office at the next appointment without fail**. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered**. I have read all the information on this sheet and have completed the about answers.

This Information and any further personal health information will be kept confidential.

_____ Date:_____

Signature of patient, parent or guardian

_____

Print Name of Patient, Parent or Guardian (circle Parent/Guardian if not the patient)

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 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)

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

HIPAA PRIVACY FORM 1

NOTICE OF PRIVACY PRACTICES

We NEVER Market or Sell personal information.

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically. On October 1, 2013 our office's revised and updated our version of the Notice of Privacy Practices will be posted in office and given to patients when requested. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post therevised Notice in our office as discussed above.

VINEET V. SOHONI, D.D.S.

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 IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy and security of your health information. We are also required to give you a copy of this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We will inform you promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices that are described in this Notice while it is in effect. This Notice takes effect 10/01/2013, and will remain in effect until we replace or revise it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided 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 a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. As long as you let us know in writing if you change your mind.

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

Or go to: http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

we can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, and in our office.

USES AND DISCLOSURES OF HEALTH INFORMATION

We can use and disclose health information about you for treatment, payment, and healthcare operations.

For example:

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

Bill for your Services: We may use and disclose your health information so you can obtain reimbursement for services we provide to you.

Run our Organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary.

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

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

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or 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 healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Other ways we can use or share your health information:

We are allowed or required to share your information in other ways- usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues: We can share health information about you for certain situations such as: Preventing disease, Helping with product recalls, Reporting adverse reactions to medications, Reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health or safety.

Research: We can use or share your information for health research.

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

Comply with the Law: We will share information about you if state or federal laws require it, including the Department of Health and Human Services if it wants to see that we're complying with federal privacy 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.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you: for workers' compensation claims; For law enforcement purposes or with a law enforcement official; with health oversight agencies for activities authorized by law; For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

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

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 practicably 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 listed 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 $1.00 for each page, which includes payment for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact

us using the information listed at the end of this Notice for a full explanation of our fee structure.) We will provide a copy or a summary of your health information, usually within 30 days of your request.

Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. But we may say "no" to your request, but we'll tell you why in writing within 60 days.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2007. 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.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. You have the right to restrict disclosure of protected health Information to a health plan with respect to items or services for which you have paid in full out of pocket.

Ask us to limit what we use or share: You may ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, we may say "no" if it would affect your care.

Request confidential Communication: You have the right to request that we communicate with you about your health information by alternative means (for example: home, cell, or office phone) or to alternative locations/addresses to send mail. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: 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.

Obtaining a list of those with whom we've shared information: You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment and health care operations, and certain other disclosures(such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any actions.

File a complaint if you feel you rights are violated: You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can also file a complaint with the U.S. Department of Health and Human Services office for Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, D.C. 20201, Calling 1-877-696-6775 or visit www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form. If our practice adopts electronic health records, we will include your rights to an accounting of electronic disclosures for treatment, payment and health care operations.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to 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 the U.S. Department of Health and Human Services 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. To File a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to:U.S. Department of Health and Human Services Office for Civil Rights; 200 Independence Avenue S.W.;Washington D.C. 20201;Call: 1-877-696-6775;Or on the Web: www.hhs.gov/ocr/privacy/hipaa/complaints/To File a complaint with our office or have questions about our office's Privacy Practices

Please contact our HIPAA Officer:

Contact Officer: Vineet V. Sohoni, D.D.S.

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