



## Patient and Insurance Information

Date \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Patient Name

First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Last \_\_\_\_\_

Preferred Name \_\_\_\_\_

Birth Date \_\_\_\_\_ Gender M F Marital Status \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell phone number \_\_\_\_\_ Home phone number \_\_\_\_\_

E-mail address \_\_\_\_\_

Is it ok for our office to communicate with you by email Y N Is it ok for our office to communicate with you by text message Y N

Emergency contact name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to patient \_\_\_\_\_

### Responsible Party Information

Who is the responsible party? (circle one) self / spouse / parent / guardian / power of attorney

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Last Name \_\_\_\_\_

Birth Date \_\_\_\_\_ Cell phone number \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

E-mail address \_\_\_\_\_

### Insurance Information

Primary Insurance Name \_\_\_\_\_ Employer \_\_\_\_\_

Subscriber ID or social security number \_\_\_\_\_

Secondary Insurance Name \_\_\_\_\_ Employer \_\_\_\_\_

Subscriber ID or social security number \_\_\_\_\_

## Medical History Form

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Physician Name \_\_\_\_\_ Phone number \_\_\_\_\_

Have you ever been hospitalized, had a major operation or any serious head or neck injury? (circle Y or N) Y N

If yes, when and for what? \_\_\_\_\_

Are you taking any medications, pills, drugs or supplements? Y N please list \_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? Y N

Do you need to premedicate before dental appointments? Y N, with what medication? \_\_\_\_\_

Pharmacy name and address \_\_\_\_\_

When was your last dental cleaning? \_\_\_\_\_ have you had problems with previous dental treatment? \_\_\_\_\_

Are you allergic to any of the following?

aspirin Y N penicillin Y N codeine Y N sulfa drugs Y N local anesthesia Y N latex Y N metal Y N  
other allergies \_\_\_\_\_

Women: are you? pregnant/trying to get pregnant? Y N nursing? Y N taking oral contraceptives? Y N

Do you have or have you ever had?

AIDS/HIV positive	Y N	cortisone medicine	Y N	hemophilia	Y N
alzheimer's disease	Y N	diabetes	Y N	anaphylaxis	Y N
hepatitis	Y N	renal dialysis	Y N	anemia	Y N
emphysema	Y N	high blood pressure	Y N	arthritis/rheumatism	Y N
high cholesterol	Y N	artificial heart valve	Y N	excessive bleeding	Y N
asthma	Y N	fainting/dizziness	Y N	irregular heartbeat	Y N
blood disease	Y N	kidney problems	Y N	acid reflux	Y N
frequent headaches	Y N	liver disease	Y N	stroke	Y N
low blood pressure	Y N	cancer	Y N	lung disease	Y N
chemotherapy	Y N	seasonal allergies	Y N	mitral valve prolapse	Y N
osteoporosis/osteopenia	Y N	tuberculosis	Y N	pain in jaw joints	Y N
heart pacemaker	Y N	heart disease	Y N	psychiatric care	Y N
ulcers/intestinal probs	Y N	glaucoma/eye probs	Y N	immunocompromised	Y N
sjogren's syndrome	Y N	tobacco use	Y N	migraines	Y N
radiation treatments	Y N	drug addiction	Y N	herpes/cold sores	Y N
epilepsy or seizures	Y N	artificial joint	Y N	sinus trouble	Y N
breathing problems	Y N	bruise easily	Y N	thyroid disease	Y N
heart attack/failure	Y N	sleep apnea	Y N	congenital heart disease	Y N
covid -19 vaccine	Y N				

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

***Signature of patient/parent/guardian/power of attorney***

\_\_\_\_\_ Date \_\_\_\_\_

## Consent to treatment and acknowledgement of risk

Print Patient Name \_\_\_\_\_

Birth Date \_\_\_\_\_

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We appreciate the opportunity to work with you in maintaining your dental health. It is important to understand that no health care is completely risk free and although all precautions will be taken to prevent or limit complications of treatment there are certain risks that you need to be aware of. The following are known risks of treatment and there are other uncertain risks as well.

- Use of any medication can cause allergic reactions with swelling, redness, itching, pain, nausea, diarrhea, vomiting or more severe allergic reactions.
- Possible stress on the jaw (TMJ) due to prolonged opening of the mouth during treatment. The result can be joint discomfort or restricted jaw movements for some time, especially when TMJ symptoms existed before treatment.
- Treatment such as fillings and crowns can cause sensitivity to hot or cold foods and liquids. Any tooth treatment with deep fillings or crowns may need future root canal treatment.
- Any injection of local anesthetic can cause pain, bruising, muscle soreness, or restricted jaw movements for some time and of varying lengths and degrees, on rare occasions being permanent.
- Dental treatment can also cause possible numbness or changes in sensation of the lip, chin, gums and/or tongue. This is called paresthesia and can be temporary or in rare occasions permanent.
- Dental procedures create fine water spray or "aerosols" which may remain in the air for several minutes to hours. These aerosols may contain viruses such as COVID-19 and may create a risk of exposure. You cannot wear a protective mask over your mouth to reduce exposure during treatment as your healthcare providers need access to your mouth to render care. This leaves you vulnerable to viruses such as COVID-19 transmission while receiving dental treatment.

To provide a safe environment for our patients and staff this practice follows the applicable state and federal regulations and protocols for infection control, universal personal protection and disinfection. The risks of treatment are not limited to those listed above. I understand that dentistry is not an exact science and that treatment can change while in progress due to unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I have truthfully revealed all aspects of my health history and acknowledge that any dental treatment has some risks associated. I consent and authorize the dentist and staff to perform such procedures as necessary and desirable in the exercise of professional judgement.

X \_\_\_\_\_ Date \_\_\_\_\_

Signature of patient or legal representative

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Print name and relationship to patient (ex. parent, guardian, power of attorney)

## Office and Payment Policies

Print Patient Name

Birth date

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- We do not tolerate:
  - Aggressive behavior
  - Physical assault or threatening gestures
  - Verbal abuse, insults and harassment
  - Sexual or racist language
  - Intimidation
  - Failure to follow staff instruction may result in dismissal from the practice

There will be a \$50.00 fee charged for each appointment cancelled with less than 24 hour notice and all broken appointments.

Payment is due at the time of service, we accept cash, check, Visa, MasterCard, Discover and American Express. If you need to finance your dental care, we accept CareCredit. For more information about CareCredit or to apply, you can visit [www.carecredit.com](http://www.carecredit.com).

Our office is only in-network with *some* Excellus Blue Cross Blue Shield plans, we do NOT participate with Excellus Healthplex, Excellus Child Health Plus, Excellus Blue Choice Option or Medicaid.

Some dental insurance plans will only send payment for services directly to the subscriber of the dental policy therefore payment will be due in full at the time of service. For your convenience we will submit the dental insurance claim to your insurance company and they will reimburse you directly based on your plan benefits.

**Please remember that you are responsible for all fees charged by this office regardless of your insurance coverage.**

X \_\_\_\_\_ Date \_\_\_\_\_

Signature of patient or legal representative

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Print name and relationship to patient (ex. parent, guardian, power of attorney)

## Notice of Privacy Practices

Print Patient Name

Birth Date

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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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9/23/2013, and will remain in effect until we replace 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

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.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU** We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

**Treatment.** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

**Payment.** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations.** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

**Individuals Involved in Your Care or Payment for Your Care.** We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

**Disaster Relief.** We may use or disclose your health information to assist in disaster relief efforts.

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

**Public Health Activities.** We may disclose your health information for public health activities, including disclosures to:

- o Prevent or control disease, injury or disability;
- o Report child abuse or neglect;
- o Report reactions to medications or problems with products or devices;
- o Notify a person of a recall, repair, or replacement of products or devices;
- o Notify a person who may have been exposed to a disease or condition; or
- o Notify the appropriate government authority if we believe a patient has been victim of abuse, neglect, or domestic violence.

**National Security.** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

**Secretary of HHS.** We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker's Compensation.** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Law Enforcement.** We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities.** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Judicial and Administrative Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

**Research.** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

**Coroners, Medical Examiners, and Funeral Directors.** We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

**Fundraising.** We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

#### **Other Uses and Disclosures of PHI**

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

#### **Your Health Information Rights**

**Access.** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Disclosure Accounting.** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

**Right to Request a Restriction.** You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

**Alternative Communication.** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must 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. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

**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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

**Right to Notification of a Breach.** You will receive notifications of breaches of your unsecured protected health information as required by law.

**Electronic Notice.** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

**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 if 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.

Our Privacy Official: Aaron J. Park, DDS  
Telephone: (585) 266-4860  
Address: 753 Titus Avenue Rochester, NY 14617  
E-mail: info@irondequoitfamilydentistry.com

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I understand and acknowledge my rights as detailed in the Notice of Privacy Practices Presented here. I understand and consent to my medical information being used as described here. I understand the terms and authorize the practice to disclose my medical information to those parties as mentioned here.

X \_\_\_\_\_ Date \_\_\_\_\_

Signature of patient or legal representative

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Print name and relationship to patient (ex. parent, guardian, power of attorney)