Patient Information

Patient Name: _____ **Date:** _____
Last, First MI (Preferred Name)

Gender: _____ **Family Status:** _____

Social Security #: _____ **Birth Date:** _____

Phone (Mobile): _____ **(Work):** _____ Ext: _____ **(Home):** _____

Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact _____**Relationship**_____ **Number**_____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

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

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints/Valves
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ 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
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy**
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ _____

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

• Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Are you currently taking any medications? ☐ Yes ☐ No
If yes, please list: _____

• Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

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 doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

We are not part of any dental network and do not accept payment from insurance companies. If you have dental insurance please fill out below and we will be happy to assist you with the paperwork and submitting your insurance claims on your behalf for reimbursement to you.

Primary

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

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

Insured's Home Address ***Only if different than your own***: _____
Street City State Zip Code

Insured's Employer Name: ***Only if different than above:*** _____
Name of Company

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address to mail dental claims: _____
Name of Plan

_____
P.O. Box Number/Street City State Zip Code

Consent for Services

As a condition of your treatment by this office, payment is due at the time of service. 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. Please be advised failure to confirm will result in cancellation of appointment, and there will be a fee for no shows/same day cancellations.

Patients who carry dental 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 dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

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

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

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

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

MANHATTAN PROSTHETIC DENTISTRY, PLLC
ROCKEFELLER CENTER
630 5th Avenue, Suite 1853-1854
New York, New York 10111

NOTICE OF PRIVACY PRACTICES

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 United States Department of Health and Human services, effective August 9, 2002, issued comprehensive federal regulations providing for protection of private medical information with which our office must comply. The final regulation, which goes into effect April, 2003, is designed to protect patient's identifiable health information. These protections are part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). (If more stringent state laws exist, these must be observed).

The HIPAA privacy rule states that after April 14, 2003, health providers must provide patients with a written Notice of Privacy practices and make a good faith attempt to obtain a written acknowledgement of such. This information should be provided to patients prior to or at the time of the first delivery of health services, except in cases of emergency. However, if a written acknowledgement is not obtainable, the attempt by the provider to obtain it is sufficient to comply with the rule.

In addition a Notice of Privacy Practices must be displayed prominently and available for patients to take home. If the notice is modified in the future, the new version must be displayed and available, and thereafter provided to patients at the time of their first treatment.

Requires language from the Department of Health and Human Services Standards for Privacy of Individually Identifiable Health Information: "THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."

The Health Insurance Portability and Accountability Act of 1996 requires that health providers keep your medical and dental information private. The HIPAA privacy rule states that health providers must also provide patients with a written Notice of Privacy Practices. This notice is dated 2/15/2003. The Privacy Practices described will be in effect after this date. And until or if they are replaced. Our office Privacy Practices may change from time to time. If changes are made, a new Notice of Privacy Practices will be displayed and provided to our patients. You may obtain additional copies of this Notice upon request. Additional information may be obtained by the Contact Officer listed on this notice.

USES AND DISCLOSURE OF INFORMATION

From Department of Health and Human Services. Standards for Privacy of Individually Identifiable Health Information, Parts 160-164.The following describes how information may be used.

TREATMENT SERVICES

We may use or provide your health information to all of our staff members, lab technicians, other dentists, your physicians, and/or other healthcare providers taking care of you. We may also provide mail, phone or electronic contacts as appointments reminders, recommendations of treatment alternatives, information about other health services and/or other office services. We do post daily schedules in the operatories, including name, phone contact, and treatment to be rendered.

PAYMENT AND OPERATIONS

We may provide your health information as required to allow for payment of services and participation in quality assurance, disease management, training, licensing, and certification programs.

MARKETING

We will not use your health information for marketing purposes without written consent.

WEB CONSENT

Internet Communications

I grant my permission to Manhattan Prosthetic Dentistry to upload and store confidential patient information — including, appointment information— to the secured web site for Manhattan Prosthetic Dentistry. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand Manhattan Prosthetic Dentistry and my self are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that Manhattan Prosthetic Dentistry is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand Manhattan Prosthetic Dentistry is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the Manhattan Prosthetic Dentistry web site with my ID and password. I also agree to immediately notify Manhattan Prosthetic Dentistry of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand Manhattan Prosthetic Dentistry will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Manhattan Prosthetic Dentistry has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand Manhattan Prosthetic Dentistry will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand Manhattan Prosthetic Dentistry cannot and does not assume any responsibility for my use or misuse of patient information ---transmitted, monitored, stored, uploaded or received using the services.

LEGAL REQUIREMENTS

We may disclose your health information when required by law.

THREAT TO HEALTH AND SAFETY

If abuse or neglect is reasonably suspected, we may disclose your health information to the appropriate governmental authorities.

NATIONAL SECURITY

When required, we may disclose military personnel health information to the Armed forces. Information may be given to authorized federal officials when required for intelligence and national security activities. Health information for inmates in custody of law enforcement may also be provided to correctional institutes.

FAMILY MEMBERS, FRIENDS, AND OTHERS INVOLVED IN CARE

At your request, we may disclose your health information to a family member or other person if necessary to assist with your treatment and/or payment for services. Based on our judgment and as per 164.522(a) of HIPAA we may disclose your information to these persons in the event of an emergency situation. We also may make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays for you. Your information may be disclosed to assist in notifying a family member, care giver, or personal representative of your location, condition, or death.

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PATIENT RIGHTS

You have the right to see your information and receive copies of your records under most circumstances. Your request must be addressed in writing addressed to the contact officer listed on this Notice. You may be charged for the cost of making copies including the actual copies and staff time. Postage will be added if request of copies are asked to be mailed. A summary of your health information can also be requested for a fee. Details of all the costs are available from our contact officer.

You may request a listing of any situations where we or our business associates disclosed your health information for purposes other than treatment, payment, or other activities for the last years, but not before April 14, 2003. You may be charged for casts associated with our response.

You may request that we observe additional restrictions on the disclosure of your information. We are not required to agree to these restrictions, but we may do so (except in case of an emergency).
If you believe that changes should be made to your health information, you must provide an explanation as to why changes should be made. Even with your request, changes may be refused under certain circumstances.

If you would like to receive your health information in an alternate format or at a specified location you must make your request in writing.

PATIENT AUTHORIZATIONS

You may give us your written authorization to use or disclose your health information to anyone for any purpose. This authorization may be revoked, in writing, at any time. Without your written authorization, disclosures about your health information are limited to those listed in the Notice.

QUESTIONS AND COMPLAINTS

If you have a complaint or need more information about our privacy practices please let us know. Your complaint may be related to a perceived violation of your privacy rights, access to your health information, requested changes in your records, or for any other reason. If you want to submit a written complaint to the U.S. Department of Health and Human Services we can provide you with the address. We completely support your right to privacy and will not retaliate should you decide to lodge a complaint.

Telephone: 212.541.6220
Fax: 212.541.6221
E-mail: contact@manhattanpd.com
Website: www.manhattanpd.com

Acknowledgement of Receipt of Notice of Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 requires that health care providers give patients a copy of the office Notice of Privacy Practices and make a good faith effort to obtain acknowledgement of receipt of the same. *You may refuse to sign this acknowledgement form.*

By signing this form I confirm that I have received a copy of the office Notice of Privacy Practices.

Print name _____

Sign name _____

Date _____

Web Consent

*** Emails will be used for confirmation of appointments; appointment reminders and treatment follow up. Please enable your settings to activate the automatic confirm link.**

I have read the information regarding the secured uploading of patient information to the web site for Manhattan Prosthetic Dentistry and grant Manhattan Prosthetic Dentistry permission to securely upload my email address, appointment date and time to confirm my appointments.

By signing this form I confirm that I grant Manhattan Prosthetic Dentistry permission to upload my information to confirm my appointments.

Print name _____

Sign name _____

Date _____

FOR OFFICE USE ONLY

Written acknowledgement was not obtained.

- Patient refused to sign: Privacy Practices/Web Consent
- Emergency situation
- Unable to communicate with patient
- Other_____

_____