Three Pages Below

EAST HAMPTON **Dental Group**

easthamptondental.com

East Hampton Dental Group

Welcome! We appreciate the trust you have shown by selecting our office to care for your dental needs. We will make every effort to make your visit as comfortable as possible. To help us meet all your healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us—we will be happy to help!

Date: ____________________

Name: ____________________ ___ ____________________ Preferred Name: ____________________
First M Last

Male **Female** **Married** **Single** **Child** **Other**

Date of Birth: ______/______/______ Social Security #: ______/______/______

Home Phone: ____________________ Mobile: ____________________ Work: ____________________

Address: ____
Apartment #/Street

____
City

____
State, Zip Code

Whom may we thank for referring you to our office:
Yellow Pages
Newspaper
School
Other: ____________________

Email Address: ____

RESPONSIBLE PARTY INFORMATION

If same as above, please skip

Name: ____________________ ___ ____________________ **Male** **Female**
First M Last

Date of Birth: ______/______/______ Social Security #: ______/______/______

Relationship to patient: **Parent/Guardian** **Other:** ____________________

Home Phone: ____________________ Mobile: ____________________ Work: ____________________

Address: ______________________________ ______________________________
Apartment #/Street City, State, Zip Code

EMPLOYMENT INFORMATION OF RESPONSIBLE PARTY

Employer: ______________________________ Occupation: ______________________________

Address: ______________________________ ______________________________
Apartment #/Street City, State, Zip Code

DENTAL HISTORY

Reason for today's visit/main concern? ☐ **Cleaning/Check up** ☐ **Emergency/Toothache** ☐**Other:** ______________

____

Previous Dentist: ____

Do your gums bleed easily? ☐ NO ☐YES Explain: ____________________________________

Have you had gum (periodontal) treatment? ☐ NO ☐YES Explain: ______________________

Have you had prolonged bleeding after any dental treatment? ☐ NO ☐YES Explain: ____________

Do you grind your teeth, clench your jaw, or feel symptoms such as clicking, popping, pain or lock jaw? ☐ NO ☐YES

Are your teeth sensitive to hot or cold? ☐ NO ☐YES

Are there any other conditions we should be aware of? ☐ NO ☐YES Explain: ________________

____

____

MEDICAL HISTORY

Physicians name: ______________________________
Physicians phone #: ____________________________

Are you currently under a doctor's care? ☐ NO ☐YES
Explain: ______________________________________

Have you been hospitalized or had a serious illness within the past five years? ☐ NO ☐YES
Explain: ______________________________________
____
____

(WOMAN) Are you currently pregnant? ☐ NO ☐YES
How many months? ______________
OBGYN: _______________________________________
____

Are you required by your doctor to pre-medicate for any condition? ☐ NO ☐YES
Drug name and quantity: ________________________

Do you currently smoke or use tobacco products?
Have you ever smoked tobacco?

Please list all medications you are currently taking and for what condition, if any: ____________________
____
____
____
____
____

PLEASE CHEACK IF YOU CURRENTLY HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING

☐ ARTIFICIAL JOINTS	☐GLAUCOMA
☐ ARTIFICIAL HEART VALVE	☐HEADACHE
☐ AIDS	☐HIV
☐ ANEMIA	☐DIZINESS/FAINTING
☐ ANGINA	☐VENEREAL DISEASE
☐ ARTHRITIS	☐STOMACH ISSUES
☐ ASTHMA	☐STD:______________
☐ BLOOD DISEASE	☐HEPATITIS:☐A☐B☐C
☐ EXCESSIVE BLEEDING	☐JAUNDICE
☐ KIDNEY DISEASE	☐EPILEPSY
☐ DIABETES	☐CANCER
☐ CHEMO/RAD THERAPY	☐LIVER PROBLEM
☐ HIGH BLOOD PRESSURE	☐LUNG DISEASE
☐ LOW BLOOD PRESSURE	☐PACEMAKER
☐ RHEUMATIC FEVER	☐SINUS TROUBLE
☐ SLEEP APNEA	☐STROKE
☐ THYROID PROBLEM	☐TUBERCULOSIS
☐ HEART MURMUR	☐HEART ATTACK

Are there any **other** health problems of which we should be advised? Please specify: ______________________
____
____
____

ALLEGIES/ADVERSE REACTIONS TO:

☐**Penicillin**	☐**Local anesthetic**	☐**Sulfa Drugs**
☐**Ibuprofen**	☐**Tetracycline**	☐**Codeine**
☐**Latex**	☐**Erythromycin**	☐**Other:______**

____

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 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. These notices will remain in effect until we replace them.

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 a new notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about your 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.

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 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 credentials 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.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify, or assist in the notification of (including identifying or indicating) 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 determinations using our professional judgment disclosing only your health information that is directly relevant to the persons 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.

MARKETING HEALTH-REALTED 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 your health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

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.

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, 2003. 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 those additional requests.

RESTRICTIONS: You may 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 ill abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that we communication with you about your health information by alternative means or to alternative locations. (You must make this 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.

ELECTRONIC NOTICE: If you received this notice on our web site or by electronic email, you are entitled to receive this notice in written form as well.

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 may also 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 to 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.

East Hampton Dental Group
300 Pantigo Place, Suite 114, East Hampton, NY 11937
Telephone: (631)324-6800, Fax: (631)324-7744, ehdental@gmail.com

I, ____ have received a copy of this office's Notice of Privacy Practices.

____ Signature of patient/parent/guardian

____ Date

East Hampton Dental Group Policy

As a courtesy to me, the office staff will help prepare and file the insurance claims should I be insured. However, the agreement of the insurance company to pay is a contract between myself and the insurance company and does not relieve my responsibility to pay for services provided at East Hampton Dental Group. I understand that East Hampton Dental Group does not participate with any insurance company. I understand that East Hampton Dental Group expects full payment at the time services are rendered unless other arrangements have been made prior to the start of any treatment.

I certify that I have read and accurately answered the above information to the best of my knowledge. I understand that providing the incorrect information can be dangerous to my health. I hereby authorize East Hampton Dental Group to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnoses of my dental condition. If I ever have any changes in my health, I will inform the doctors at the appointment without fail.

____ Signature of patient/parent/guardian

____ Date

CHILD/MINOR CONSENT

I, ____ being the parent/guardian of (child) ____________________________ do hereby authorize East Hampton Dental Group to perform the necessary dental services for my child, including but not limited to, radiographs and anesthesia which are deemed advisable by the doctor. Whether or not I am physically present at the actual appointment when the treatment is rendered.

____ Signature of parent/guardian

____ Date