Expert Dental P. C.
www.expertdentalnyc.com
110 E 40th ST | Suite 104 • New York, NY 10016
info@expertdentalnyc.com
(212)682-2965

Welcome to Expert Dental!

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or if patient is under 18.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Primary Dental Insurance:

Name of Insured: _____ _____ _____
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Company Address and Phone Number:

_____

_____

Insurance Subscriber ID, Date of Birth, and Insurance Group Number:

_____

_____

Secondary Dental Insurance

Name of Insured: _____ _____ _____
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Company Address and Phone Number:

_____

_____

Insurance Subscriber ID, Date of Birth, and Insurance Group Number:

_____

_____

Insurance Authorization:

☐ * **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Medical History

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *Pre-Med - Amox
- ☐ *Pre-Med - Other
- ☐ Allergy - Codeine
- ☐ Allergy - Latex
- ☐ Allergy- Levaquin
- ☐ Allergy- Percocet
- ☐ Artificial Joints
- ☐ Cancer
- ☐ Epilepsy
- ☐ Head Injuries
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Nervous Disorders
- ☐ penicillin allergy
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Venereal Disease
- ☐ *Pre-Med - Amox
- ☐ AIDS
- ☐ Allergy - Erythro
- ☐ Allergy - Other
- ☐ Allergy- Lidocaine
- ☐ Allergy-Amoxicillin
- ☐ Asthma
- ☐ Coumadin
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ HIV
- ☐ Mental Disorders
- ☐ No Epi
- ☐ Pregnancy
- ☐ Rheumatism
- ☐ Tuberculosis
- ☐ *Pre-Med - Amox
- ☐ Allergies
- ☐ Allergy - Hay Fever
- ☐ Allergy - Penicillin
- ☐ Allergy- Omnicef
- ☐ Anemia
- ☐ Back Problems
- ☐ Diabetes
- ☐ Fainting
- ☐ Heart Murmur
- ☐ Jaundice
- ☐ MVP
- ☐ Other
- ☐ Radiation Treatment
- ☐ Sinus Problems
- ☐ Tumors
- ☐ *Pre-Med - Clind
- ☐ Allergy - Aspirin
- ☐ Allergy - Ibuprofen
- ☐ Allergy - Sulfa
- ☐ Allergy- Omnicef
- ☐ Arthritis
- ☐ Blood Disease
- ☐ Dizziness
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Neck Problems
- ☐ Pacemaker
- ☐ Respiratory Problems
- ☐ Stomach Problems
- ☐ Ulcers

- ☐ Ever been hospitalized (illness or injury)
- ☐ Taking medication for weight control (ie fen-phen)
- ☐ Subject to frequent headaches
- ☐ FEMALE: Taking birth control pills
- ☐ Presently being treated for any other illnesses
- ☐ Taking dietary supplements
- ☐ A smoker or smoked previously
- ☐ FEMALE: Pregnant

If any conditions or alerts selected above need further clarification, please describe below:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain.

_____

_____

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your physician and your most recent physical exam:

_____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

_____

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin.

_____

_____

_____

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist name and how long have you been a patient there:

_____

_____

Date of most recent dental exam: _____

Date of most recent dental x-rays: _____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

_____

_____

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____

Personal History, Check all that apply:

☐ Had an unfavorable dental experience ☐ Had complications from past dental treatment ☐ Had trouble getting numb

☐ Had any reactions to local anesthetic ☐ Had/have braces, orthodontic treatment ☐ Had your bite adjusted

☐ Had any teeth removed

Smile Characteristics, Check all that apply:

- [ ] Is there anything about the appearance of your teeth that you would like to change?
- [ ] Have you ever whitened (bleached) your teeth?
- [ ] Have you felt uncomfortable or self conscious about the appearance of your teeth?
- [ ] Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint, Check all that apply:

- [ ] You have problems with your jaw joint
- [ ] You have problems chewing
- [ ] Your teeth changed in the last 5 years, become shorter, thinner, or worn
- [ ] Your teeth are crowding or developing spaces
- [ ] You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
- [ ] You clench your teeth in the daytime or make them sore
- [ ] You have problems with sleep or wake up with an awareness of your teeth
- [ ] You wear or have worn a bite appliance

Tooth structure, Check all that apply:

- [ ] Cavities within past 3 years
- [ ] The amount of saliva in your mouth seems too little or you have difficulty swallowing any food
- [ ] You notice or have holes (i.e. pitting, crates) on the biting surface of your teeth
- [ ] Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth
- [ ] Grooves or notches on your teeth, chipped teeth, or had a toothache or cracked filling
- [ ] Food gets caught between any teeth

Gum and Bone, Check all that apply:

- [ ] Gums bleed when brushing or flossing
- [ ] Treated for gum disease or were told you have lost bone around your teeth
- [ ] Noticed an unpleasant taste or odor in your mouth
- [ ] History of periodontal disease in your family
- [ ] Experienced gum recession
- [ ] Had any teeth become loose on their own (without injury), or have difficulty eating an apple
- [ ] Experienced a burning sensation in your mouth

If any of the checked boxes need further explanation, please describe:

Consent for Services and Financial Policy

Financial Information

As a condition for treatment at Expert Dental P.C., financial agreement is made in advance. Patients are responsible for the cost incurred for the dental treatment agreed upon by the patient. Patient who carry dental insurance understand that all dental services performed are charged directly to the patient and that he or she is personally responsible for the payment of their dental care. Payment may be made with cash, credit card, care credit payment plans and any other payment arrangement that is authorized by the office in advance. Any account balance over 30 days will be charged interest at a rate of 1.75% per month and/or late fees and service charges, where applicable. We require 48 hours notice for cancellation of appointments or you will be charged $100 for missed appointments without proper notice. Most Insurance companies will not reimburse the cost of a missed appointment.

Dental Insurance

Insurance is only an estimate of benefits. We do not have a contract with your insurance company, only you do. We can only assist you in estimating your portion of the cost of treatment. The type of plan chosen by you and/or employer determines your benefits. As such, we have no control over the terms of your contract, the method of reimbursement or the determination of your insurance benefits. Insurance and patient portions are estimates provided as a courtesy. In the event that your insurance carrier pays less than the estimated amount, you are fully responsible for the unpaid balance. Submission of insurance claims and/or adjustment of fees may not be done retroactively. I understand that I am responsible for all co-payments and deductibles at the time of service.

Authorization for Signature on File

Patient release of information and acknowledgement of financial responsibility. Patient hereby authorize Expert Dental P.C. to affix my name to any and all claims and documents as related to any and all health benefits due to me.

To the extent permitted under applicable law, I authorize release of any information relating to the claim. The "Signature On File" will be valid from this date until withdrawn. A photocopy of this document may act as an original.

☐ *** By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.**

Credit Card In File Form

We are committed to meeting your dental care needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. The card on file will not be charged without you being notified first.

CARDHOLDER INFORMATION

First Name * _____

Last Name * _____

Billing Address *

_____

_____

City * _____

State * _____

Postal Code * _____

Direct Telephone * _____

CREDIT CARD INFORMATION

Credit Card Type *

◯ MasterCard ◯ Visa ◯ American Express ◯ Discover Card

Number *

_____

_____

Expiration Month * _____

Expiration Year * _____

Security Code * _____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the credit card authorization form.**

HIPAA Acknowledgement

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.

OUR PLEDGE REGARDING DENTAL INFORMATION

The privacy of your dental information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our dental office. We need this record to provide you with the quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share dental information about you. We also describe your rights and certain duties we have regarding the use and disclosure of dental information. Throughout this notice we refer to your medical information as dental information.

OUR LEGAL DUTY

Law Requires Us to:

1. Keep your dental information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your dental information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all dental information that we keep, including information previously created or received before the changes.

Notice of Change of Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR DENTAL INFORMATION

The following section describes different ways that we use and disclose dental information. For each kind of use or disclosure, we will explain what we mean and give an example. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose dental information. We will not use or disclose your dental information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use dental information about you to provide you with dental treatment or services. We may disclose dental information about you to doctors, nurses, technicians, or other people who are taking care of you. We may also share dental information about you to other healthcare providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your dental information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your dental information.

FOR HEALTHCARE OPERATIONS: We may use and disclose your dental information for our healthcare operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your dental information for treatment, payment, and healthcare operations, we may use and disclose dental information for the following purposes.

Notification: We may use and disclose dental information to notify or help notify: a family member, your personal representative or another person responsible for your care. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your healthcare, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, dental supplies, x-ray or other dental information for you.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of dental information.

Funeral Director, Coroner, and Medical Examiner: To help them carry out their duties, we may share the dental information of a person who has died with a coroner, medical examiner,

funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use dental information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose dental information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your dental information with law enforcement officials. We may share limited information with a law enforcement official concerning the dental information of a suspect, fugitive, material witness, crime victim or missing person. We may share the dental information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your dental information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your dental information to persons subject to jurisdiction of the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose dental 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 share your dental information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share dental information when necessary to help law enforcement officials capture a person who may be part of a crime or has escaped from legal custody

Workers Compensation: We may disclose dental information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose dental information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose dental information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain type of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use disclose dental information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Dental Services: We may use and disclose dental information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

Security and Quality Control: For quality control purposes as well as the safety of our staff and patients, operatories and exam rooms may be under closed circuit video surveillance. By execution of this notice, you acknowledge and agree to such video surveillance to satisfy the quality control of this facility and to promote the safety and security of our patients and staff.

YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your dental information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. It may take up to 10 days for us to have the information ready for you. You may get the form to request access by using contact information listed at the beginning of this notice. You may also request access by sending a letter to the contact person listed at the beginning of this notice. If you request copies, we will charge you $0.75 for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the beginning of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your dental information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your dental information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your dental information by different means or to different locations. Your request that we communicate your dental information to you by different means or at different locations must be made in writing to the contact person listed at the beginning of this notice.

5. Request us to change parts of your dental information. We may deny your request if we did not create the information you want to change or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your

request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice, or if you think that we may have violated your privacy rights, please contact us. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

Expert Dental PC
110 East 40th Street Suite #104
New York, NY 10016

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Consent for E-mail Communications

Patient e-mail address

_____

_____

1. RISK OF USING E-MAIL

Expert Dental ("the Practice") offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before using e-mail. Please note that most standard email does not provide a secure means of communication. There is some risk that any protected health information contained in email may be disclosed to, or intercepted by, unauthorized third parties. In addition, there is always a risk that the email could be sent to the wrong person, usually because of a typing mistake or selecting the wrong name in an auto-fill list. Use of more secure communications, such as phone or fax is an always an alternative that is available to you.

2. CONDITIONS FOR THE USE OF E-MAIL

The Practice will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, the Practice cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by the Practice's intentional misconduct. Thus, patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions:

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are a part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails.
b. The Practice may forward e-mails internally to the Practice's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling.
c. Although the Practice will endeavor to read and respond promptly to an e-mail from the patient. The Practice cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient shall not use e-mail for medical emergencies or other time-sensitive matters.
d. If the patient's e-mail requires or invites a response from the Practice, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
e. The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
f. The patient is responsible for informing the Practice of any types of information the patient does not want to be sent by e-mail, in addition to those set out in 2(e) above.
g. The patient is responsible for protecting his/her password or other means of access to e-mail. The Practice is not liable for breaches of confidentiality caused by the patient or any third party.
h. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. PATIENT ACKNOWLEDGMENT & AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Practice and me, and consent to the conditions outlined herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that the Practice may impose to communicate with patients by e-mail. Any questions I may have had were answered.

☐ * **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.**

Response Date: ____/____/_____