

WELCOME

Patient Information

Date _____
SS/HIC/Patient ID # _____
Patient Name _____
Last Name _____
First Name _____ Middle Initial _____
Address _____
E-mail _____
City _____
State _____ Zip _____
Sex M F Birthdate _____ Age _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
Patient Employer/School _____
Occupation _____
Employer/School Address _____
Employer/School Phone (____) _____
Spouse's Name _____
Birthdate _____
SS# _____
Spouse's Employer _____
Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance? Yes No
Subscriber's Name _____
Birthdate _____ SS# _____
Relationship to Patient _____
Insurance Co. _____
Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship to Patient _____

Phone Numbers

Phone (____) _____ Work (____) _____ Ext _____ Alt. Phone (____) _____
Spouse's Work (____) _____ Best time and place to reAlt. you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____
Phone (____) _____ Work Phone (____) _____

Dental History

| | | |
|--|--|---|
| Reason for today's visit _____ | Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Former Dentist _____ | Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No |
| City/State _____ | Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No | Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Date of last dental visit _____ | Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Date of last dental X-rays _____ | Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No | Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Place a mark on "yes" or "no" to indicate if you have had any of the following: | Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No | Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No | Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No | Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No | Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No | How often do you floss? _____ |
| | Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Health History

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. Yes No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- | | | | | | |
|---|--|-----------------------|--|------------------------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No Due date _____ Are you nursing? Yes No

Taking birth control pills? Yes No

Medications

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone (____) _____

Allergies

- | | |
|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | _____ |

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

.....
Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Jefferson Valley Dental Associates

3654 Lee Blvd.

Jefferson Valley, NY 10535

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dentist's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Your protected health information may also be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for the treatment.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training, licensing, and conducting or arranging for other business activities. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your dentist is not required to agree to a restriction that you may request. If dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice is valid throughout the duration of treatment. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____

Insurance and Payment Policy

Thank-you for choosing Jefferson Valley Dental as your dental service provider, where the doctors and staff welcome you. In an effort to deliver optimal care, we would like to share with you some facts regarding insurance that may play a role in your treatment plans. This form is to advise you, the patient, of the financial arrangement policies at this office, your responsibilities and methods of payment.

In most instances, we have insurance forms on file. However, certain Union plans require a signed insurance form each visit, if this is the case we will help you process your claim but the form must be completed and signed by the insured before your visit. It is entirely your responsibility to keep track of any yearly or lifetime maximums that you may have with your policy. Sometimes we do not receive this information from the insurance company. You will be responsible for any additional charges.

Your insurance policy is a contract between you and your insurance company. Remember that all insurance policies are different. Please be aware that some services provided may be non-covered services, in which case you are responsible for payment. We will offer as a courtesy to you, our patient, assistance in handling all the paperwork and even file the claim and pre-treatment estimates for you. Please be aware that some insurance companies may not honor a pre-treatment estimate or may alter it. Again, you will be responsible for any non-payment or short payment by the insurance company. Our policy is as follows.

Insurance

All copays, payments, and deductibles are due at the time service is rendered. If you carry insurance, the difference that the insurance does not cover is also due at that time unless financial arrangements are made. Confirmation of a valid insurance is required before each visit. If any change is made in the insurance policy such as a cancellation, insurance carrier change, or benefits change we are to be notified, in writing, before your next visit. A failure to notify us of a change will result in patient responsibility for the amount due. Any remaining balance after all insurance claims have been received is the patient's responsibility.

Method of Payment

We accept cash, check, and all major credit cards, except Discover Card. Credit cards may be charged at the time of visit. Any options for ongoing financial agreements must be discussed and agreed upon ahead of treatment. We will accept credit card payment by phone. Checks will not be accepted at the first visit, cash, or credit card only. Any check that is returned there will be a \$35 fee payable to Jefferson Valley Dental in addition to the amount owed for treatment and future checks will be subject to denial by Jefferson Valley Dental. If you are allowed to continue writing checks after a check is returned and you have a 2nd return, the fee again will be \$35 plus what is owed from treatment and no more checks will be accepted. Your payment will be due by cash or credit card, no exceptions.

Care Credit

We also accept care credit as a method of payment. This is a financing option that requires an application and approval of credit line. Please inquire if you have any questions or are interested in applying.

Collections

For past due accounts 90 days or three billing cycles the account will be sent to a collection agency. To avoid this situation, payment may be made by cash, check, or credit card. Any account with ongoing financial arrangement will not go to collections as long as payments are being made regularly according to what has been agreed upon.

We apologize that we have such an involved office policy concerning insurance. However, from past experience, we have learned that sometimes there is a big difference in what coverage you think or have been told that you have and what the insurance actually pays.

Upon signing this statement, you are agreeing to and understand all the terms, conditions, and payment arrangements listed. You also understand that failure to comply with these terms, conditions, and payment arrangements could result in a report to a collection agency.

The bottom line of our policy is that we will help you all we can, but the difference in what the insurance company pays and the charges for the services we provide for you is due from you. Please do not hesitate to ask us if you have any questions about the above information. We are here to help you. Please sign that you have read and understand this. Thanks for your understanding.

Patient, or Parent/Guardian Signature

Date

CANCELLATION & MISSED APPOINTMENT POLICY

Our goal at Jefferson Valley Dental Associates is to provide you with convenient, accessible, high quality Dental care. In order for us to assure convenience and accessibility to all of our patients, it is important that patients arrive timely for all scheduled appointments or cancel the appointment **24 hours** in advance. This policy allows us to make better use of our available appointments for those patients in need of Dental care.

Cancellation of an Appointment

You may cancel your scheduled appointment by calling our office during regular business hours. Appointments are in high demand and your early cancellation will give another patient the opportunity to be seen by a provider.

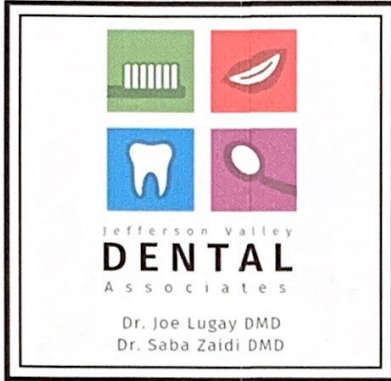
Missed Appointment Policy

We will call you **48 hours** in advance to remind you of your scheduled appointment. **(Please make sure we have your updated contact information.)** If it is necessary to cancel/reschedule your appointment we ask that you call us at least **24 hours** in advance at **914-245-4760**. In the event a **24 hours** notice of cancellation is not given, a fee of **\$35.00** may be assessed for an office appointment. These fees are not covered by your insurance and are your personal responsibility.

Thank you!

Patient/Guardian's Signature

Signature Date



Oral Cancer Screening Form

Patient Name: _____

Date: _____

To assist us in implementing a more comprehensive evaluation during your visit with us today, please indicate if you have experienced or noticed the following:

1. Any swelling or pain in your face, mouth neck, tonsils or throat?
Yes ___ No ___
Explanation: _____
2. Any painless, non-moving, firm bumps on your neck?
Yes ___ No ___
Explanation: _____
3. Any mouth sores lasting more than 1 week?
Yes ___ No ___
Explanation: _____
4. Any surface changes or bleeding in your mouth?
Yes ___ No ___
Explanation: _____
5. Any changes in the way things have recently tasted?
Yes ___ No ___
Explanation: _____
6. Any changes in the way your voice sounds?
Yes ___ No ___
Explanation: _____
7. Any difficulty when swallowing or eating?
Yes ___ No ___
Explanation: _____
8. Any recent changes in your weight?
Yes ___ No ___
Explanation: _____
9. Any numbness or tingling in your face?
Yes ___ No ___
Explanation: _____
10. Any recent changes in your vision?
Yes ___ No ___
Explanation: _____