DentAlign Studio
62-22 Myrtle Ave.
Glendale, N.Y. 11385

PATIENT PERSONAL INFORMATION

Title _____ Nickname _____ Birth Date _____ Age _____

Last, First _____, _____ Martial Status _____ Sex _____

Address _____ Home # _____ Work # _____

City, State, Zip _____ Cell # _____ SSN _____

Email _____

PERSON RESPONSIBLE FOR PAYING BILLS

Title _____ Nickname _____ Birth Date _____ Age _____

Last, First _____, _____ Martial Status _____ Sex _____

Address _____ Home # _____ Work # _____

City, State, Zip _____ Cell # _____ SSN _____

Email _____

Do you have Primary Dental Insurance? ___ YES ___NO **Do you have Secondary Dental Insurance? ___ YES ___ NO**

Insurance Company _____

Group Number _____

Subscriber's Name _____

Birth Date _____

Social Security # _____

Complete if you have secondary insurance

Secondary Company _____

Secondary Group # _____

Subscriber's Name _____

Subscriber's DOB _____

Subscriber's SSN _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the company listed herein, and I assign directly to DentAlign Studio 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. DentAlign Studio may use my information and disclose such information to my insurance companies named herein and their agents for the purpose of obtaining payment for the services completed and determining insurance benefits payable for related services.

_____

Signature of Patient, Guardian, or Representative

EMERGENCY CONTACT INFORMATION

Name _____ Employer _____

Address _____ City /State / Zip _____/_____/_____

Phone Number _____ Relationship _____

HEALTH HISTORY

Allergies

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Erythromycin
- ☐ Iodine
- ☐ Latex Rubber
- ☐ Local Anesthetics
- ☐ Metals
- ☐ No Epinephrine
- ☐ Penicillin
- ☐ Prior Hepatitis
- ☐ Sulfa Drugs
- ☐ Other Narcotics
- ☐ NONE

Please Check If Applicable

☐ No Concerns	☐ AIDS/HIV Infection	☐ Alcohol/Drug Abuse	☐ Anemia/Leukemia	☐ Ankles Swell
☐ Anorexia	☐ Arthritis	☐ Asthma/Hay Fever	☐ Blood Clotting	☐ Blood Transfusion
☐ Bronchitis	☐ Cancer/Tumor	☐ Cardiac Pacemaker	☐ Chest Pain	☐ Color Blindness
☐ Contact Lenses	☐ Damaged Heart Valve	☐ Diabetes	☐ Emphysema	☐ Environmental Allergies
☐ Epilepsy	☐ Fainting Spells	☐ Fever Blisters /Herpes	☐ Frequent Dry Mouth	☐ Gall Bladder Trouble
☐ Heart Attack	☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis / Jaundice	☐ High Blood Pressure
☐ Hives	☐ Joint Replacement	☐ Kidney/Bladder Trouble	☐ Liver Disease	☐ Low Blood Pressure
☐ Mental Health Issues	☐ Mitral Valve Prolapse	☐ Persistent Diarrhea	☐ Premedicate	☐ Rheumatic Fever
☐ Sinus Trouble	☐ Shortness of Breath	☐ STD	☐ Stomach Ulcers	☐ Thyroid Problems
☐ Tuberculosis	☐ Unusual Weight Loss	☐ Urinate Frequently		

DENTAL QUESTIONNAIRE

Name of Previous Dentist / Phone Number _____

What can you tell me about yourself that will enable us to work better together? _____

_____

What are your expectations of me? _____

_____

What would you change about your mouth if you didn't have any obstacles in the way? _____

_____

What might these obstacles be? _____

Date of your last x-rays _____

What is your immediate Dental concern? _____

Does Dental Treatment make you nervous? _____

Have you lost any teeth? How? _____

Do you have more than one bite? _____

Do you have any growths or swelling in your mouth? How long have they been there? _____

Do your gums bleed while brushing or flossing? ☐

Are your teeth sensitive to hot, cold or sweets? ☐

Have you ever had burning of the tongue or cracking of the corners of your mouth? ☐

Do you chew/smoke tabacco in any form? ☐

Have you had any head, neck or jaw injuries? When? _____

Do you notice popping, clicking or soreness of the jaws or in front of the ears? ☐

Do you clench or grind your teeth? ☐

Have you ever had orthodontic treatment? When? _____

Do you wear dentures or partials? ☐

Are you happy with your dentures? ☐

Are you happy with your smile? If not, why? _____

Do you have problems with teeth/fillings breaking? ☐

Do you have an unpleasant taste or odor in your teeth/mouth? ☐

Does food catch between your teeth? ☐

MEDICAL QUESTIONNAIRE

Family Physician / Phone Number _____

Are you currently under the care of a physician? _____

If yes, what is the condition being treated? _____

Have you had any serious illness, operation or been hospitalized for the past 5 years? _____

If yes, what illness or problem? _____

Do you use alcoholic beverages? How many per day? _____

Do you smoke? How many packs per day? _____

Medications

Please list all medications you are taking with the dosage and related conditions:

_____

_____

Have you taken bisphosphonates? _____

WOMEN ONLY

Are you pregnant? When is your due date? _____

Are you currently nursing? _____

Do you have menstrual period problems? _____

Are you on hormone replacement therapy? _____

Are you on birth control pills / fertility drugs? _____

ADDITIONAL COMMENTS

Any disease, condition or problem not listed? please list _____

By signing below, I certify that all of the above information is true to the best of my knowledge.

_____ _____

Patient/Guardian Signature **Date**

DentAlign Studio

Informed Consent Form for General Dental Procedures

****DEAR PATIENT PLEASE BE ADVISED THAT THIS DENTIST IS OUT OF NETWORK WITH ALL INSURANCES. ANYTHING NOT PAID BY YOUR INSURANCE WILL BE 100% YOUR RESPONSIBILITY.****

You, the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do Not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you have a heart condition or heart murmur, advise your dentist immediately so she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying wit the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

1. Pain, swelling, and discomfort after treatment
2. Infection in need of medication, follow-up procedure or other treatment.
3. Temporary, or on rare occasion, permanent numbness, pain, tingling, or altered sensation of the lip, face, chin, gums and tongue along with possible loss of taste.
4. Damage to adjacent teeth, restorations or gums
5. Possible deterioration of your condition which may result in tooth loss
6. The need for replacement of restorations, implants or other appliances in the future
7. An altered bite in need of adjustment
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist
9. Allergic reaction to anesthetic or medication
10. Need for follow up including surgery

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

_____ _____ _____

Patient Signature Date Print Patient Name

Our Commitment --PLEASE MAKE SURE THAT YOU HAVE READ THIS PAGE CAREFULLY BEFORE SIGNING

DentAlign Studio is committed to the highest quality dental care possible, offering affordable services with maximum patient flexibility. Before treatment is undertaken, we will consult with you so that you fully understand the need, the procedures, and the expense of your dental treatment. Together, we will implement the best plan for your dental care. In order to achieve this, we need your understanding of our payment policy.

Payment Options

Payment is due at the time services are rendered unless other arrangements have been made in advance. In all cases, payment in full is required at treatment completion. For your convenience, we offer the following options:

VISA, MasterCard, Discover, Cash, or Checks

Dental Insurance
It is important to understand that our relationship is with you, not your insurance company. We will present a treatment plan and an estimate of expenses. Estimates are based upon available insurance information and do not guarantee payment by your insurance company. Fees that are not covered by your insurance company are 100% the patient's responsibility.

CareCredit
CareCredit is a nationally recognized credit provider, which specialize in assisting individuals with financing for their dental care. CareCredit provides patients with interest free payment plans as well as extended payment plans for patients who prefer more time to pay. Patients may be approved for CareCredit within a couple of minutes at our office. More information about using CareCredit may be obtained from our office staff. In all cases, approval for CareCredit should be arranged prior to treatment.

Collection Agency
If you have a balance due and it is not paid within 90 days your account will be turned over to a collection agency.

Composite Fillings

Some insurance plans do not cover composite fillings. This means that your insurance company downgrades the payment to an amalgam filling (silver) You will be responsible for the difference between a composite filling and an amalgam filling if this is the case. We will send you a copy of the claim from your insurance company with an explanation if this does happen.

Broken Appointment Policy

We anticipate that all patients will keep their appointments and we will make a reasonable effort to help them do so. However, situations do arise which may cause a patient to reschedule. We will gladly reschedule appointments, but we require 24 hours advance notice. Patients who fail to attend their appointments and have no provided us with 24 hours advance notice will be charged a $50.00 broken appointment fee. In addition, patients who arrive late for their scheduled appointment time may have to forfeit their appointment and may be subject to the broken appointment fee.

Acceptance of Terms --PLEASE MAKE SURE THAT YOU HAVE READ THIS PAGE CAREFULLY BEFORE SIGNING

I have read and fully understand the above financial policies, and agree to the terms outlined herein.

_____ _____

Date Signature of Patient or Guardian

_____

Print Patient Name

HIPAA Privacy Policy

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. THIS 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. This notice takes effect (04/14/03), 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, provide such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and in 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 the 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 at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use of disclose your health information to a physician of other healthcare provider pending treatment to you.
Payment: We may use of disclose your health information to obtain payment for services we provide to you.

Healthcare operations: We may use or 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, and certification licensing or credentialing activities.

Our 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 of disclosures permitted by your authorization while it was in affect. Unless you give us 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 locating) 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 of 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 determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make responsible inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other forms of health information.

Marketing Health-Related 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 to your health or safety or the 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 the authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use of 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. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice . If you request copies, we will charge you $75.00 for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information at the end of this notice for a full explanation of our fee structure.

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, health operations and certain other activities, for the last six 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 these additional requests.

Restrictions: You 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 will abide by our agreement (except in an emergency)

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means, to alternative locations. (You must make your 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 receive this notice on our web site or by e-mail you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information on 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 by using the contact information we gave you. You may also submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint to the US 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 the US Department of Health and Human Services.

For more information about HIPAA or to file a complaint:
The US Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
202-619-0257
Toll Free: 877-696-6775

ACKNOWLEDGEMENT OF RECEIVING NOTICE OF PRIVACY PRACTICES

_____

SIGNATURE

_____

PRINT NAME

_____

DATE