DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

VERONICA GREENE, D.D.S.
19 West 44th Street
Suite 314
New York, NY 10036

Telephone: (212) 997-1966

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for _____ years ☐ Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

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 doctor 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 Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

DENTAL HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

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

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ NoIf yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex _____
- ☐ Other _____

_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

Consent to Dental Treatment

Patient's Name: _____ Date: _____

I hereby authorize Dr. _____ and his/her associates to perform on me the following dental operations and/or procedures, listed on the Treatment Plan.

If any unforeseen condition arises in the course of these authorized operations and/or procedures which necessitate procedures different from or in addition to those set out above, I further authorize the Doctor to perform these procedures/operations.

I consent to this plan after having been advised of the alternate plans of treatment available, the known material risks of the treatment to be used and the consequences if this treatment were withheld.

I am informed and fully understand that there is, in any type of treatment, the possibility of certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swelling and bruising, discomfort, loss or loosening of dental restorations. Less common complications can include infection, loss or injury of adjacent teeth and soft tissues, nerve disturbances (e.g. numbness in mouth and lip tissues), jaw fractures, and small root fragments remaining in the jaw which might require extensive surgery for removal.

I further consent to the administration of local anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug responses, cardiac arrest, pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

I understand that I am responsible for all fees regardless of insurance coverage. I also understand that as treatment progresses the fees may have to be adjusted, but that I will be informed of these adjustments and how they will affect my payment plan. In the event that my payment are not received within 30 days of their due date, I agree to pay all costs of collections, including, but not limited to, reasonable attorney's fees.

Signature of Patient: _____ Date: _____

Signature of Patient or Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

Veronica Greene, DDS
Ph: 212-997-1966

19 West 44th str. Suite 314
New York, NY 10036

NOTICE OF PRIVACY PRACTICES

Effective Date: January 1st, 2004

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.

WHY ARE YOU GETTING THIS NOTICE?

Dr. Greene is required by law to protect the privacy of your health information. She is also required to provide you with a copy of this notice. It describes the health information privacy practices of Dr. Greene's office. If you have questions about this notice or would like further information, please contact Dr.Greene at 212-997-1966. Dr. Greene will ask you to sign an "acknowledgment" indicating that you have been provided with this notice.

WHO FOLLOWS THE POLICIES IN THIS NOTICE?

The privacy practices described in this notice are followed by any health care professional that treats you in Dr. Greene's office, all employees, trainees or volunteers providing services in Dr. Greene's office. All business associates of Dr.Greene's (see paragraph 1 – If, for a description of business associates).

WHAT HEALTH INFORMATION IS PROTECTED?

Dr. Greene is committed to protecting the privacy of information she gather about you while providing health-related services. Some examples of protected health information are:

Information that you are a patient in Dr. Greene's office or that you are receiving treatment or other health-related services from Dr. Greene or her staff; iInformation about your health condition (such a disease you may have);

Information about health care products or services you have received or may receive in the future; or Information about your health care benefits under an insurance plan (such as whether a particular dental procedure or service is covered);

When combined with: Demographic information (such as your name, address, or insurance status); unique numbers that may identify you (such as your chart number, social security number, your phone number); and other type of information that may identify who you are.

SUMMARY OF THIS NOTICE

This summary includes references to paragraphs throughout this notice that you may refer to for additional information.

A. *Written Authorization Requirement. Dr. Greene may use your health information or share it with other in order to treat your condition, obtain payment for that treatment, and run her business operations (see paragraph 1-1). Dr. Manea is generally required to obtain your written authorization for further use and disclosures of your health information unless an exception described in this notice applies.*

B. *Authorizing Transfer of Your Records. You may request that Dr. Greene transfer your records to another person or organization by completing a written authorization form. This form will specify what information is being release, to whom, and for what purpose. The authorization may have an expiration date.*

C. *Canceling Your Written Authorization. If you provide Dr. Greene with written authorization, you may revoke, or cancel at any time, except to the extent that Dr. Greene has already relied upon it. To revoke a written authorization, please write to the office.*

D. *Exceptions to Written Authorization Requirement. There are some situations in which Dr. Greene doesn't need your written authorization before using your health information or sharing with other. They are:*

1) *Treatment, Payment and Operations. As mentioned above, Dr.Greene may use your health information or share it with other in order to treat your condition, obtain payment for the treatment, and run her business operations (see paragraph 1-1).*

2) *De-Identified Information. Dr. Greene may also use and disclose your health information if she has removed any information that might identify you. Dr. Greene may also use and disclose "partially de-identified" information if the person who will receive it agrees in writing to protect your privacy when using the information. (See paragraph 1-4).*

3) *Incidental Disclosures. Dr. Greene may inadvertently use or disclose your health information despite having taken all reasonable precautions to protect the privacy and confidentiality of your health information. (See paragraph 1-5)*

4) *Emergencies or Public Need. Dr. Greene may use or disclose your health information in an emergency or for important public health needs. For example, she may share your information with public health officials at the NY State or city health departments who are authorized to investigate and control the spread of disease.(See paragraph 1-6).*

E. *How to Request Alternative Communications. You have the right to request that Dr. Greene contact you in a way that is more confidential for you, such as at home instead of at work. Dr. Greene will try to accommodate all reasonable requests. (See paragraph III-1).*

F. *How to Access Your Health Information. You generally have the right to inspect and get copies of your health information (see paragraph III-2).*

G. *How to Correct Your Health Information. You have the right to request that Dr. Greene amend your health information if you believe it is inaccurate or incomplete (See paragraph M-3).*

H. *How to Identify Others Who Have Received Your Health Information. You have the right to receive an "accounting of disclosures". This is a report that identifies certain persons or organizations to which Dr. Greene has disclosed your health information. All disclosures are made according to protections described in this Notice of Privacy Practice. Many routine disclosures Dr. Greene makes (for treatment, payment, or business operations) will not be included in this report. However, it will identify many non-routine disclosures of your information.(See paragraph III-4).*

I. *How to Request Additional Privacy Protections. You have the right to request further restrictions on the way Dr. Greene uses your health information or share it with others. However, Dr. Greene is not required to agree to the restriction you request. If Dr. Greene agrees with your request, she will be bound by this agreement. (See paragraph III-5).*

J. *How Someone May Act on Your Behalf. You have the right to name a personal representative who may act in your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of your health information about minors unless the minors are permitted by law to act on their own behalf.*

K. *How to Learn About Special Protections for HIV, Alcohol and Substance Abuse, and Mental Health. Special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information and mental health information.(See paragraph II).*

L. *How to Obtain a Copy of This Notice. If you have not already received one, you have the right to a paper copy of this notice. You may request a paper copy at any time.*

M. *How to Obtain a Copy of Revised Notice. Dr. Greene may change her privacy practices from time to time. If she does, she will revise this notice so you will have an accurate summary of her practices. Dr. Greene will post any revised notice in her reception area. You may also ask for one at the time of your next visit. The effective date of this notice is noted on the first page. Dr. Greene is required to abide by the terms of the notice that is currently in effect.*

N. *How to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with Dr. Greene or with the Secretary of the United States Department of Health and Human Services. To file a complaint with Dr. Greene please write to the office. No one will retaliate or take action against you for filling a complaint.*

I. *HOW DR. MANEA MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION.*

1) Treatment, Payment and Business Operations. Dr. Greene may use your health information or share it with other in order to treat your condition, obtain payment for that treatment, and run her business operation.

a. *Treatment. Dr. Greene may share your health information with specialists, staff or other allied dental professionals who are involved in taking care of you. They may, in turn, use that information to diagnose or treat you. Dr. Manea may also share your health information with other health care providers who referred you to her and/or to whom you have been referred for further health care.*

b. *Payment. Dr. Greene may use your health information or share with others so that she may obtain payment for your health care services. For example, Dr. Greene may share information about you with your health insurance company. This will help her obtain reimbursement after she has treated you, or determine whether your health insurance will cover your treatment. She might also need to inform your health insurance company about your health and dental condition in order to obtain pre-approval for your treatment.*

c. *Business Operations. Dr. Greene may use your health information or share with others in order to conduct her business operations. For example she may use your health information to evaluate the performance of her staff members*

who provide care to you. Dr. Greene may also share your health information with other health care providers to help them with their business operations.

d. *Appointment Reminders, Treatment Alternatives, Benefits and Services. In the course of providing treatment for you, Dr. Greene may use your health information to contact you with a reminder that you have an appointment for treatment or services at her office. She may also use your health information in order to recommend alternatives or health related benefits and services that may be of interest to you.*

e. *Business Associates. Dr. Greene may disclose your health information to contractors, agents and other business associates who need the information in order to assist his with obtaining payment or carrying out her business operations. For example, she may share your health information with a billing company that helps her to obtain payment from your insurance company. Another example is that she may share your health information with an accounting firm or law firm that provides professional advice. If she does disclose your health information to a business associate, Dr. Greene will have a written contract to ensure that her business associate also protects the privacy of your health information.*

2) Families and Friends Involved in Your Care. If you do not object, Dr. Greene may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for that care.

3) Completely De-Identified or Partially De-Identified Information. Dr. Greene may use and disclose your health information if she has removed any information that has the potential to identify you, so that the health information is "completely de-identified". She may also use and disclose "partially de-identified" health information about you for certain purposes if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will not contain any information that would directly identify you (such as name, street address, chart number, social security number, phone number, fax number, electronic mail address, website address).

4) Incidental Disclosures. While Dr. Greene will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur or as an unavoidable result of her otherwise permissible uses or disclosures of your health related information.

5) Public Need.

a. As Required By Law. Dr. Greene may use or disclose your health information if she is required by law to do so. She also will notify you of these uses and disclosures if notice is required by law.

b. Public Health Activities. Dr. Greene may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities. For example, Dr. Greene may share your health information with government officials who are responsible for controlling disease, injury or disability.

c. Victims of Abuse, Neglect, or Domestic Violence. Dr. Greene may release your health information to a public health authority or other authorized governmental authority if she reasonable believes you have been a victim of abuse, neglect, or domestic violence. She will make every effort to obtain your permission before releasing this information, but in some cases she may be required or authorized to act without your permission.

d. Health Oversight Activities. Dr. Greene may release your health information to government agencies authorized to conduct audits, investigations, and inspections of her office. These government agencies monitor the operation of the health care system and compliance with government regulatory programs ~d civil rights laws.

e. Product Monitoring, Repair, and Recall. Dr. Greene may disclose your health information to a person or a company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems;)2) repairing, replacing or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

f. Lawsuits and Disputes. Dr. Greene may disclose your health information if he is ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute.

g. Law Enforcement. Dr. Greene may disclose your health information to law enforcement officials for the following reasons: To comply with court orders or laws that Dr. Greene is required to follow; To assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person; if you have been the victim of a crime and Dr. Greene determines that: (1) she has been unable to obtain your agreement because of an emergency or your incapacity; (2) law enforcement officials need this information immediately to carry out their law infringement duties; and (3) in her professional judgment disclosure to these officers is in your best interests; If Dr. Greene suspects that your death resulted from criminal conduct; If necessary to report a crime that occurred in her office; or if necessary to report a crime discovered during an off site medical emergency.

h. To Avert A Serious And Imminent Threat to Health or Safety. Dr. Greene may use your health information or share it with other when necessary to prevent a serious or imminent threat to your health or safety, or the health or safety of another person

or the public. In such cases, Dr. Greene will only share your information with someone able to help prevent the threat. Dr. Greene may also disclose your health information to law enforcement officers: 1) if you tell her that you participated in a violent crime that may have caused serious physical harm for another person (unless you admitted that fact while in counseling), or 2) if she determines that you escaped from lawful custody (such a prison or mental health institution).

i. National Security and Intelligence Activities or Protective Services. Dr. Greene may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

j. Military and Veterans. If you are in the Armed Forces, Dr. Greene may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military mission. Dr.Greene may also release health information about foreign military personnel to the appropriate foreign military authority.

6. Workers Compensation. Dr. Greene may disclose your health information for workers compensation or similar programs that provide benefits for work- related injuries.

7. Coroners, Medical Examiners, and Funeral Directors. In the unfortunate event of your death, Dr. Greene may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. Dr. Greene may also release this information to funeral directors as necessary to carry out their duties.

II. SPECIAL PROTECTIONS FOR CERTAIN TYPES OF INFORMATION

The following kinds of health information are considered so sensitive that state or federal laws provide special protections for them:

Information about IV testing or test results, information about substance abuse rehabilitation treatment, and information about mental health treatment or status. Dr. Greene may be required to, and will when required, obtain your written authorization before she can use or disclose these types of information to the government, in some instances in which she could use or disclose other types of information without your written authorization, as described in this Notice.

Ill. YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

Dr. Greene wants you to know that you have the following rights to access and control your health information. These rights are important because they will help you make sure that the health information she has about you is accurate. They may also help you control the way she uses your information and share it with other, or the way she communicates with you about dental and health issues.

1). Your Right to Request Alternative Communications. You may request that Dr. Greene communicate with you by alternative means or at alternative locations. For example you may wish to receive communications at work rather than at home. To request alternative communications, please contact the office. She will not ask you for the reason for your request, and will try to accommodate all reasonable requests. Please specify in your request how or when you wish to be contacted.

2) Your Right To Inspect and Obtain Copies of Your Records. You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes dental and billing records.

a. How to Make Your Request. To inspect or obtain a copy of your health information, please submit your request in writing to the office.

b. Cost. If you request a copy of the information, Dr. Greene may charge a fee for the cost of copying, mailing or other supplies she uses to fulfill your request.

c. Respond. Dr. Greene will respond to your request for inspection of records within 10 days. She ordinarily will respond to requests for copies within 30 days if the information is located in the office and within 60 days if it is located off-site at another facility.

d. If Your Request Is Denied. Under certain very limited circumstances, Dr. Greene may deny your request to inspect or obtain a copy of your information. If she does, she will provide you with a summary of the information instead. She will also provide a written notice that explains her reason for providing only a summary and a complete description of your rights to have that decision reviewed and how you can exercise those rights. If she has reason to deny only part of your request, she will provide complete access to the remaining parts after excluding the information she cannot let you inspect or copy.

3) Your Right to Amend Records. If you believe that the information that Dr. Greene has about you is incorrect or incomplete, you may ask her to amend the information. You have the right to request an amendment for as long as the information is kept in her records.

a. How to Make Your Request. To request an amendment, please write to the office. Your request should include the reasons why you think she should make the amendment.

b. Response Time. Ordinarily Dr. Greene will respond to your request within 30 days.

4) Your Right to an Accounting of Disclosures. After January 1st, 2004, you have a right to request an "accounting of disclosures" of your Health information, which identifies other persons or organizations to which Dr. Greene has disclosed your health information in accordance with applicable law and this Notice. An accounting of disclosures will not include the following disclosures: Disclosures for treatment, payment and business operations; Disclosures Dr. Greene made pursuant to your written authorization; Disclosures made to your friends and family involved in your care or payment for your care; Disclosures that were incidental to permissible uses and disclosures of your health information; Disclosures of de-identified health information; Disclosures for national security or intelligence purposes; Disclosures to law enforcement officials; Disclosures made prior to January 1st , 2004.

a. How to Make Your Request. To request an accounting of disclosures, please write to the office. Your request must state a time period (but after January 1st, 2004) for the disclosures you want Dr. Greene to include. You have the right to receive one accounting within every 12-month period for free. However, Dr. Greene may charge you for any additional accounting in that same 12- month period. Dr. Greene will always notify you of any cost involved so that you may choose to withdraw or modify your request before any cost are incurred.

b. Response Time. Ordinarily Dr. Greene will respond to your request for an accounting within 30 days. In rare cases Dr. Greene may have to delay providing you with the accounting because a law enforcement official or government agency has asked her to do so.

5) Your Right to Request Additional Privacy Protections. You have the right to request that Dr. Greene further restrict the way she uses and discloses your health information for treatment, payment or business operations. You may also request that Dr. Greene limits how she discloses information about you to family and friends involved in your care. For example, you could request that she not disclose information about a dental procedure you had.

a. How to Make Your Request. To request restrictions, please write to the office. The request should include what information you want to limit; whether you want Dr. Greene to limit her use of the information, how she shares it with other, or both; and to whom the limits apply.

B Dr. Greene is not required to agree to your request for a restriction. In some cases the restriction you request may not be permitted by law; if however Dr. Greene agrees to the restriction she will be bound by the agreement unless the information is needed to provide you with emergency treatment or comply with the law. Once Dr. Greene has agreed to a restriction, you may revoke the restriction at any time. Under some circumstances, she will also have the right to revoke the restriction as long as she notifies you before doing so; in other cases, she will need your permission before she can revoke the restriction.

6) Complaints. If you believe your privacy rights have been violated, you may file a complaint with Dr. Greene or with the Secretary of the United States Department of Health and Human Services. To file a complaint with Dr. Greene please write to the office. No one will retaliate or take action against you for filing a complaint.

7. Changes to Dr. Greene's Privacy Practices. Dr. Greene may change her privacy practices from time to time. If she does so, she will revise this Notice, which will apply to all health information. She will post any revised Notice in the reception area. You may also obtain a copy of the revised Notice.

If you have any questions about this notice please write to the office at:

19 West 44th street, Suite 314

New York, NY 10036

VERONICA GREENE, DDS

19 West 44th Street
Suite 314
New York, NY 10036

Phone: 212-997-1966

Notice of Privacy Practices Patient Acknowledgement

Patient's Name: _____ *Date of Birth:* _____

I have received and understand this Practice's Notice of Privacy Practices written in plain language. This notice provides in details the uses and disclosures of my protected health information that may be made by this Practice, my individual rights and the Practice's legal duties with respect to my protected health information.

This Practice reserves the right to change the terms of its Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur , this practice will provide me a revised Notice of Privacy Practices upon request.

*Signature:*_____ *Date:* _____

Relationship to Patient (if signed by a personal representative of patient): _____