WELCOME

Woodbury Family Dental
Donald L. Cohen, DMD

Patient Information

Name_____ _____ _____ ☐ Male ☐ Female
Last First MI

Social Security #_____-_____-_____ Birthdate _____-_____-_____ ☐ Single ☐ Married ☐ Child ☐ Other

Phone(Home)_____(Work)_____(Ext.)_____

When is the best time to call_____ Preferred Appointment Time:_____

Spouse_____ _____ Birthdate _____-_____-_____
Last First

Children_____Birthdate _____-_____-_____ _____ Birthdate _____-_____-_____

_____Birthdate _____-_____-_____ _____ Birthdate _____-_____-_____

Address_____Apt_____
Street

_____ _____ _____
City State Zip

Employer_____Occupation_____

_____ _____ _____ _____
Address City State Zip

How did you first hear of Us? _____

Responsible Party Information

Name_____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Other

Address_____ _____ _____ _____
Street City State Zip

Birthdate _____-_____-_____ Social Security #_____-_____-_____ Phone(home)_____

Employer _____ Phone (work) _____

Address_____ _____ _____ _____
Street City State Zip

Insurance Information

Insured's Name_____ Birthdate ____-_____-____ S. S. #_____-_____-_____

Insured's Employer_____Phone_____

Address_____ _____ _____ _____
Street City State Zip

Your relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Company_____Plan #_____ Group #_____

Address_____ _____ _____ _____
Street City State Zip

Phone_____ **Do you have a secondary insurance?** ☐ Yes ☐ No

PATIENT MEDICAL AND DENTAL QUESTIONARE

PHYSICIAN'S NAME _____ Last Dental Visit _____

_____ Reason for visit _____
ADDRESS

_____ _____ _____ Last Dental X-rays _____
CITY ST ZIP

(____)_____ Last Dental Checkup _____
PHONE

Why are you here today? _____

Have you had any of the following? Please check those that apply.

☐ AIDS	☐ EMPHYSEMA	☐ HIGH BLOOD PRESSURE	☐ PREGNANCY
☐ ALLERGIES	☐ EPILEPSY	☐ HIV	☐ RADIATION TREATMENT
☐ ANEMIA	☐ EXCESSIVE BLEEDING	☐ JAUNDICE	☐ RESPIRATORY PROBLE
☐ ARTHRITIS	☐ FAINTING	☐ KIDNEY DISEASE	☐ REHEUMATIC FEVER
☐ ARTIFICIAL JOINTS	☐ GLAUCOMA	☐ LATEX ALLERGY	☐ SINUS PROBLEMS
☐ ASTHMA	☐ GROWTHS	☐ LIVER DISEASE	☐ STOMACH PROBLEMS
☐ AUTOIMMUNE DISEASE	☐ HAY FEVER	☐ LYME DISEASE	☐ STROKE
☐ BLOOD DISEASE	☐ HEAD INJURIES	☐ MENTAL DISORDERS	☐ THYROID
☐ CANCER	☐ HEART DISEASE	☐ MITRAL VALVE PROPLASE	☐ TUBERCULOSIS
☐ CODEINE ALLERGY	☐ HEART MURMUR	☐ NERVOUS DISORDERS	☐ TUMORS
☐ DIABETES	☐ HEMOPHILIA	☐ PACEMAKER	☐ ULCERS
☐ DIZZINESS	☐ HEPATITIS	☐ PENICILLIN ALLERGY	☐ VENEREAL DISEASE

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ YES ☐ NO

If yes, for what? _____

Are you allergic to aspirin, codeine, penicillin or any other drugs or medications? ☐ YES ☐ NO

If yes, what? _____

Have you ever had any complications following Dental Treatment? ☐ YES ☐ NO

If yes, what? _____

Are you now under the care of a physician? ☐ YES ☐ NO If yes, for what? _____

Do you have any disease, condition or problem not listed? ☐ YES ☐ NO If yes, what? _____

Are you taking any medications? ☐ YES ☐ NO If yes, what? _____

Have you ever been treated for or diagnosed as having TMJ or gum disease? ☐ YES ☐ NO

If yes, please explain: _____

CHILDREN...

Are you taking fluoride or using fluoride rinses **daily**? ☐ YES ☐ NO

WOMEN...

Are you pregnant? ☐ YES ☐ NO Is there a possibility you are pregnant? ☐ YES ☐ NO

Are you nursing? ☐ YES ☐ NO

To the best of my knowledge all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____

Signature of Patient, Parent or Guardian Date

ABOUT FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with best possible care. If you have dental or medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa or Discover. We will be happy to help you process your insurance claim-form for your reimbursement. Any such request must be accompanied by a *completed* insurance form at each visit. In *special* instances we may accept assignment of insurance benefits.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1 1/2% per month. Charges may also be made for broken appointments and appointments canceled without 24 hours advance notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage(such as 50% or 80%) of "U.C.R.". "U.C.R." is defined as usual, customary and reasonable fees for this region. Thus, our fees are considered usual, customary and reasonable by most companies.

This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

Consent for Routine Treatment and Dental Local Anesthesia/Analgesia Acknowledgment of Financial Policy

Treatment:

The purpose and nature of the dental treatments have been fully explained to me. I have been fully informed of, and understand fully, all of the risks involved in the performance of the treatment to be rendered. I understand that there is a possibility of complications developing during or after the treatment and these have been fully explained to me. I am now giving my free and voluntary consent for the treatment to be rendered. I have not been given nor received any guarantees as to the results to be obtained from the dental treatment I am to receive.

Local Anesthesia & Analgesia(Nitrous Oxide):

I have been told that there will be local anesthesia administered and the type and nature of such local anesthesia, as well as any risks involved in such administration and of local anesthesia itself, have been fully explained to me; and I do give my free and voluntary consent to same. This will include only local anesthesia and/or nitrous oxide administration, neither of which will be issued to render me unconscious.

Acknowledgment:

I acknowledge my financial responsibility(as explained on the previous page) and I also acknowledge that I have filled out the medical history to the best of my ability(if assistance is needed, please ask the front desk).

Release of Information: I authorize release of any medical information from my physician.

Date_____

Signature of Patient(Guardian)_____

NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, costmanagement analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14th, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Dr. Donald Cohen
Woodbury Family Dental
100 Triangle Plaza
Suite #14
Harriman, New York 10926
(845) 782-1800
(845) 782-3116

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Notice of Privacy Practices Acknowledgement

Woodbury Family Dental
100 Triangle Plaza, Suite #14
Harriman, New York 10926

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

SIGNATURE ON FILE

Telephone: (845) 782-1800 Fax (845) 782-3116

WOODBURY FAMILY DENTAL
Donald Cohen, D.M.D.
118 River Road, Suite 14
Harriman, N.Y. 10926

Release and Assignment

Date _____

To _____
Insurance Company

_____

Group No._____ Certificate No. _____

I hereby authorize Woodbury Family Dental, its dentists and DR. DONALD COHEN, D.M.D. to release to your company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care.

I also authorize and request your company to pay directly to the above named doctor the amount due me in my pending claim for Dental treatment or services, by reason of such treatment or services rendered to:

_____
Patient

_____
Signature of Insured

_____
Address