DENTAL SPECIALTY ASSOCIATES

PATIENT NAME: _____ CHART# _____ DATE: _____
LAST FIRST MI

MALE FEMALE MARRIED SINGLE CHILD OTHER _____

SOCIAL SECURITY# _____ DATE OF BIRTH _____ E-MAIL ADDRESS _____

PHONE# (HOME) _____ WORK _____ EXT _____ CELL _____

ADDRESS _____
STREET APT# CITY STATE ZIP

I. CHECK APPROPRIATE ANSWER (Leave blank if you do not understand the question)

YES NO IS YOUR GENERAL HEALTH GOOD?
YES NO HAS THERE BEEN A CHANGE IN YOUR HEALTH WITHIN THE LAST YEAR?
YES NO HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS IN THE LAST THREE YEARS?
WHY? _____
YES NO ARE YOU BEING TREATED BY A PHYSICAN NOW? FOR WHAT? _____
DATE OF LAST MEDICAL EXAM? _____DATE OF LAST DENTAL APPOINTMENT? _____
PHYSICAN'S NAME _____ PHONE _____
YES NO HAVE YOU HAVE PROBLEMTS WITH PRIOR DENTAL TREATMENT?
YES NO ARE YOU IN PAIN NOW? PLEASE EXPLAIN: _____

II. HAVE YOU EXPERIENCED

YES NO	CHEST PAIN (ANGINA)?	YES	NO	DIZZINESS?	TEMP	_____
YES NO	SWOLLEN ANKELS?	YES	NO	RINGING IN EARS?	RESP	_____
YES NO	SHORTNESS OF BREATH?	YES	NO	HEADACHES?	PULSE	_____
YES NO	RECENT WEIGHT LOSS, FEVER, NIGHT SWEATS?	YES	NO	FAINTING SPELLS?	BP	_____
YES NO	PERSISTENT COUGH, COUGHING UP BLOOD?	YES	NO	BLURRED VISION?		
YES NO	BLEEDING PROBLEMS, BRUISE EASILY?	YES	NO	SEIZURES, EPILEPSY?		
YES NO	SINUS PROBLEMS?	YES	NO	EXCESSIVE THIRST?		
YES NO	DIFFICULTY SWALLOWING?	YES	NO	FREQUENT URINATION?		
YES NO	DIARRHEA, CONSTIPATION, BLOOD IN STOOLS?	YES	NO	DRY MOUTH?		
YES NO	FREQUENT VOMIT, NAUSEA?	YES	NO	JAUNDICE?		
YES NO	DIFFICULTY URINATING, BLOOD IN URINE?	YES	NO	JOINT PAIN, STIFFNESS?		

III. DO YOU HAVE OR HAVE YOU EVER HAD? (Please check the appropriate answer)

YES NO	HEART DISEASE?	YES	NO	AIDS, ARC, HIV INFECTION?
YES NO	HEART ATTACK, HEART DEFECTS?	YES	NO	TUMORS, CANCER?
YES NO	HEART MUMURS, MITRAL VALVE PROLAPSE?	YES	NO	ARTHRITIS, RHEUMATISM?
YES NO	RHEUMATIC FEVER?	YES	NO	EYE DISEASES?
YES NO	STROKE, HARDENING OF THE ARTERIES?	YES	NO	ANEMIA, BLOOD DISEASE?
YES NO	HIGH BLOOD PRESSURE?	YES	NO	STD?
YES NO	TB, EMPHYSEMA, OTHER LUNG DISEASE?	YES	NO	HERPES?
YES NO	HEPATITIS, OTHER LIVER DISEASE, JAUNDICE?	YES	NO	KIDNEY, BLADDER DISEASE?
YES NO	STOMACH PROBLEMS, ULCERS?	YES	NO	THYROID, ADRENAL DISEASES?
YES NO	FAMILY HISTORY OF DIABETES, HEART PROBLEMS, TUMORS?	YES	NO	DIABETES?
YES NO	PRE-MEDICATED PRIOR TO DENTAL VISIT?	YES	NO	MOUTH-BREATHING?

PLEASE CIRCLE ALLERGIES: LATEX, METALS, PENICILLIN, FOODS, DRUGS, MEDICATIONS, OTHER? PLEASE LIST ALL: _____

IV. DO YOU HAVE OR HAVE YOU EVER HAD? (*Please check the appropriate answers***)**

YES NO	PSYCHIATRIC CARE?	YES	NO	HOSPITALIZATION?
YES NO	RADIATION TREATMENTS?	YES	NO	BLOOD TRANSFUSION?
YES NO	CHEMOTHERAPY?	YES	NO	SURGERIES?
YES NO	PROSTHETIC HEART VALVE?	YES	NO	PACEMAKER?
YES NO	ARTIFICIAL JOINT?	YES	NO	CONTACT LENSES?

V. DO YOU USE?

YES NO	RECREATIONAL DRUGS?	YES	NO	TOBACCO IN ANY FORM?
YES NO	ANTICOAGULANT MEDIICATION?	YES	NO	ALCOHOL?

PLEASE LIST ALL DRUGS, MEDICATIONS, OVER THE COUNTER MEDICATIONS, ASPIRIN, PHEN-FEN, DIET PILLS, SUPPLEMNETS, VITAMINS, HERBAL REMEDIES: _____

VI. PLEASE CHECK THE APPROPRIATE ANSWERS

YES NO	ARE YOU PREGNANT OR NURSING?	YES	NO	TAKING BIRTH CONTROL?
	IF SO, PLEASE EXPLAIN: _____			
YES NO	DO YOU HAVE OR HAVE YOU ANY OTHER DISEASES OR MEDICAL PROBLEMS **NOT** LISTED ON THIS FORM?			
	IF SO, PLEASE EXPLAIN: _____			

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED EVERY QUESTION COMPLETELY AND ACCURATELY. I WILL INFORM MY DENTAL PROVIDER OF ANY CHANGE IN MY HEALTH AND MEDICATION.

_____ _____ _____ _____
PATIENT'S (Parent/Guardian) SIGNATURE DATE DOCTOR'S SIGNATURE DATE

DENTAL SPECIALITY ASSOCIATES

DENTAL INSURANCE INFORMATION

If you DO NOT have dental insurance, skip to Medical Insurance Information

The following information is on the insured person:

Name: _____ Relation to Patient: _____

Social Security #_____ Birth Date: _____

Phone (Home): _____ (Work) _____ Ext _____

Address: _____
Street Apt City State Zip Code

Primary Dental Insurance Information
My Primary Dental Insurance Company Is: _____

Employment Information of Insured
Employer Name: _____ Occupation _____

Address: _____
Street City State Zip Code

Secondary Dental Insurance Information:

Name of Insured: _____
Last First MI

Patient's relationship to insured: ( ) Self ( ) Spouse ( ) Child Other _____

Insured's Birth Date: _____ ID#: _____

Insured's Employer Name: _____ Group# _____

Insurance Company Name and Address: _____

Medical Insurance Information

I have medical insurance coverage.
I do not have medical insurance coverage

Name of Medical Insurance Coverage: _____

Medical Insurance Company: _____

Name of Insured: _____ Group#: _____

Insured's ID Number: _____

Employer Who the Medical Insurance is Through: _____

Dental Specialty Associates

Financial Responsibility

Payment is expected in full at time of service

Please remember that we bill insurance companies as a courtesy to the patient and that you ultimately are responsible for all fees incurred in our office!

I understand that by signing below I am allowing Dental Specialty Associates to use the supplied information to bill insurance coverage for any services rendered and that my insurance company may send that benefit to Dental Specialty Associates (Assignment of Insurance Benefits). I also understand that any co-payments, percentages or fee schedule payments are due from me at time of service.

I am ultimately responsible for any and all balances on my account incurred in any way. I am responsible for any non-covered services, and any balances remaining after my insurance company has paid their portion.

It is my responsibility to keep my coverage active, to be familiar with my plans benefits and to know that I am covered at the time that services are rendered. Any claims denied or unpaid due to my coverage not being in force at time of services, or any other reason will be billed directly to me. It is also my responsibility to ask for a quote on any dental services before they are rendered.

_____ Date_____

Signature of patient (or legal guardian if minor)

Patient Confidentiality Policy

As our patient we want you to know that we respect the privacy of your personal information. The information you supply to us is used to carry out treatment, payment and any healthcare related operations. Use of your personal information for other purposes would require your authorization. We strive to always take reasonable precautions to protect your privacy as outlined under the HIPPA (Health Insurance Privacy and Portability Act) guidelines. We also have to right to change or amend or privacy practices. We support your right to access to your personal dental records. Our office charges fee for record copies.
You have the right to review our privacy notice, and to revoke consent in writing at any time after reviewing our privacy policies. If you have questions about our privacy policies please ask to speak to our HIPAA compliance officer on staff. Our complete privacy policies are available for reading if desired.

Print name of patient: _____

Signature: _____ Date_____

Patient signature (parent or legal guardian)

Consent for Services

As a condition of our treatment, financial arrangements must be made in advance. All emergency dental services, or any dental services performed, must be paid at the time services are performed.

We will help prepare the patients insurance forms. However, we cannot render services on the assumption that our charges will be paid in full by any insurance company.

I understand that treatment plans are estimates only and subject to change depending on unforeseen circumstances that may arise during the course of treatment.

I understand that the fees estimated for dental services can only be extended for a period of six months from the date of the patient examination.

I understand as a courtesy I should give at least 24 hours notice for all appointment changes.

I grant my permission to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their consent.

_____ Date: _____ Relationship to Patient_____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient_____

Signature of guarantor of payment/responsible party

DENTAL SPECIALTIY ASSOCIATES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

DENTAL SPECIALTY ASSOCIATES

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.
THE 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 (MM/DD/YR), 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, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and 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 listed 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 or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

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

Your 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 or disclosures permitted by your authorization while it was in effect. Unless you give us a 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 or 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 reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar 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 to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or 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 $0.___ for each page, $___ per hour 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 listed 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, healthcare operations and certain other activities, for the last 6 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.

Restriction: 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 or 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 electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about 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 using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. 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 us or with the U.S. Department of Health and Human Services.

Contact Officer: **Mario Orantes** Address: 225 Broadway New York, NY 10007

E-mail: mario@metropolitandental.com Telephone: (646) 839-8400 Fax: (212) 732-0267

Dental Claim Statement

1.
☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services
Provider ID #

2 .
☐ Medicaid Claim
☐ EPSDT
Prior Authorization #
Patient ID #

3. Carrier name and address:

PATIENT COVERAGE INFORMATION

4. Patient name
First M.I. Last

5. Relationship to employee
☐ Self ☐ Child
☐ Spouse ☐ Other _____

6. Sex
M F

7. Patient birthdate
MO DAY YR

8. If full-time student
School
City

9. Employee/ subscriber name and mailing address

10. Employee/subscriber Soc. Sec. or I.D. no.

11. Employee/subscriber birthdate
MO DAY YR

12. Employer (company) name and address

13. Group number

14. Is patient covered by another dental plan? ☐ Yes ☐ No
If "Yes," complete 12-a.
Is patient covered by a medical plan? ☐ Yes ☐ No

15-a. Name and address of carrier(s)

15-b. Group no(s).

16. Name and address of other employer(s)

17-a. Employee/subscriber name *(if different than patient's)*

17-b Employee/subscriber Soc. Sec. or I.D. no.

17-c Employee/subscriber birthdate
MO DAY YR

18. Relationship to patient
☐ Self ☐ Parent
☐ Spouse ☐ Other _____

19. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibitting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

► _____ _____
SIGNED (PATIENT OR PARENT, IF MINOR) DATE

20. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

► _____ _____
SIGNED (Employee/subscriber) DATE

BILLING DENTIST

21. Name of Billing Dentist or Dental Entity

22. Address where payment should be remitted

23. City, State, Zip

24. Dentist Soc. Sec. or TIN

25. Dentist license no

26. Dentist phone no.

27. First visit date current series

28. Place of treatment
Office Hosp ECF Other

29. Radiographs or models enclosed? No Yes How many?

30. Is treatment result of occupational illness or injury? No Yes If "Yes," enter brief description and dates.

31. Is treatment result of auto accident?

32. Other accident?

33. If prosthesis, is this initial placement?

If "No," reason for replacement

34. Date of prior placement

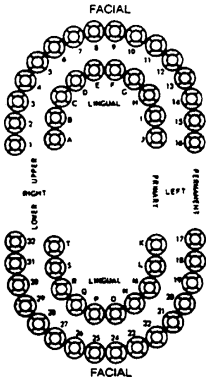
35. Is treatment for orthodontics?

If services already commenced, enter

Date appliances placed

Mos. treatment remaining

36. Identify missing teeth with "X"



37. Examination and treatment plan—List in order from tooth no. 1 through tooth no. 32—Use charting system shown.

Tooth # or letter	Surface	Description of Service *(including x-rays, prophylaxis, materials used, etc.)*	Date Service Performed Mo Day Year	Procedure Number	Fee

For administrative use only

38. Remarks for unusual services

39. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

_____ _____ _____
SIGNED (TREATING DENTIST) LICENSE NUMBER DATE

40. Address where treatment was performed

City State Zip

41. Total Fee Charged

42. Payment by other plan

Max. allowable

Deductible

Carrier %

Carrier pays

Patient pays