Dental Horizons of Westchester, P.C

PATIENT INFORMATION

TODAY'S DATE________________HOME PHONE#____________________E-MAIL___________________________________

PATIENT NAME____

ADDRESS____ CITY____

STATE_________________________ ZIP___________________CELL PHONE #______________________________________

SEX ____M ____F AGE________ BIRTHDATE_______________PATIENTS S.S#___________________________________

SINGLE_____MARRIED______ (Spouse's name)___________________ WIDOW____SEPARATED_____ DIVORCED_______

WHO REFERRED YOU TO OUR OFFICE____

BUSINESS ADDRESS____ BUSINESS PHONE#________________________

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED?_______________________Cell Phone #:_________________________

FINANCIAL RESPONSIBILITY

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL?____

TODAY'S METHOD OF PAYMENT WILL BE: CASH____________ CHECK_________________CREDIT CARD_______________

DENTAL INSURANCE

NAME OF INSURANCE POLICY HOLDER (Subscriber)____

RELATION TO PATIENT_________________________ BIRTHDATE___________________ S.S#_________________________

ADDRESS (If different from patients)____

CITY____STATE________________ZIP___________________

SUBSCRIBER EMPLOYED BY____

BUSINESS ADDRESS____ BUSINESS PHONE#___________________________

INSURANCE COMPANY____ GROUP#_____________________________________

ADDITIONAL INSURANCE COMPANY___________________________________

AUTHORIZATION

I AUTHORIZE MY INSURANCE COMPANY TO PAY TO THE DENTIST OR DENTAL GROUP ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

I AUTHORIZE THE DENTIST TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.
I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.

SIGNATURE____ DATE____

DENTAL HISTORY

1. NAME OF PREVIOUS DENTIST:________________________ PHONE #________________CITY/STATE________________
2. DATE OF LAST DENTAL VISIT?_________________________ DATE OF LAST DENTAL X-RAYS?________________________
3. HAS YOUR PHYSICIAN TOLD YOU THAT YOU REQUIRE ANTIBIOTICS BEFORE RECEIVING TREATMENT?_______________

____

4. REASON FOR LAST VISIT? ____
5. DO YOU HAVE ANY CONCERNS ABOUT PREVIOUS DENTAL CARE OR THIS DENTAL VISIT?_________________________

____

6. DO YOUR GUMS BLEED? YES NO
7. ARE YOUR TEETH LOOSE? YES NO
8. HAVE YOU EVER BEEN TOLD YOU HAVE GUM DISEASE? YES NO
9. HAVE YOU EVER BEEN TOLD YOU HAVE BAD BREATH? YES NO
10. HAVE YOUR EVER HAD ANY PAIN IN YOUR JAW JOINTS (CLICKING, POPPING)? YES NO
11. LOOSE TEETH OR BROKEN FILLINGS? YES NO
12. SENSITIVITY TO COLD? YES NO
13. SENSITIVITY TO HEAT? YES NO
14. SENSITIVITY WHEN BITING? YES NO
15. GRINDING TEETH? YES NO
16. ARE YOU HAPPY WITH YOUR SMILE? YES NO

IF NO, PLEASE EXPLAIN:____

17. ARE YOU NOW OR HAVE YOU EVER WANTED TO STRAIGHTEN YOUR TEETH WITH BRACES OR INVISALIGN?_________

____

18. WHAT WOULD YOU CHANGE ABOUT THE PRESENT CONDITION OF YOUR MOUTH?_____________________________

____

I HAVE READ ALL OF THE INFORMATION ON THIS SHEET AND HAVE COMPLETED THE ABOVE ANSWERS. I CERTIFY THIS INFORAMTION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY HEALTH STATUS.

____   ____

(SIGNATURE) (Parent or Guardian if patient is a minor)   (DATE)

HEALTH HISTORY

NAME OF PRIMARY CARE PROVIDER/PHYSICIAN_________________________ PHONE NUMBER_____________________
CITY/STATE___________________ DATE OF LAST EXAM/VISIT___________________________

PLEASE ANSWER THE QUESTION BELOW. IF YOU ANSWER YES TO ANY OF THE FOLLOWING PLEASE SPECIFY.

Currently under the care of a physician?	Y	N	Family history of Cancer?	Y	N
Smoke cigarettes and/or cigars?	Y	N	Surgery or radiation therapy for tumor, cancer or other?	Y	N
Do you drink alcohol or use recreational drugs?	Y	N	Received or receiving bisphosphonate (Actonel, Boniva, Fosamax, Skelif, and Didronel) therapy? When?	Y	N
Have you had any or do you currently have any serious medical illness?	Y	N	Currently taking aspirin, warfarin, blood thinners or anti-inflammatory drugs?	Y	N
Hospitalized within the past 5 years?	Y	N	Taken any of the group drugs collectively known as FenPhen?	Y	N
Surgery/operation?	Y	N	Abnormal bleeding with previous surgery or extractions?	Y	N
Have you received a blood transfusion?	Y	N	Do you bruise easily?	Y	N
Woman only: are you currently breastfeeding?	Y	N	Woman only: are you or may be pregnant?	Y	N

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS LISTED BELOW:

AID/HIV positive	Y	N	Heart disease/murmur	Y	N	Mental or nervous disorders	Y	N
Arthritis or other joint problems	Y	N	Diabetes	Y	N	Fainting spells/Seizure	Y	N
Blood disorders (Anemia, hemophilia, sickle cell)	Y	N	Hepatitis, Jaundice, other liver disease	Y	N	Sinus Problems	Y	N
High blood pressure	Y	N	Kidney disease	Y	N	Allergies, Hives, Rash or Hay Fever	Y	N
Cancer? Specify:	Y	N	Sexually transmitted disease(s)	Y	N	Kidney or bladder disease	Y	N
Cardiovascular (heart)Disease(s)	Y	N	Glaucoma	Y	N	Asthma, emphysema, other lung disease	Y	N
tuberculosis	Y	N	osteoporosis	Y	N	Persistent cough/coughing blood	Y	N
Artificial joints or heart valves	Y	N	Stomach problems/ Ulcers	Y	N	Thyroid problems	Y	N
Immunosuppressed	Y	N	Other:					

MEDICATIONS

LIST <u>ALL</u> MEDICATIONS YOU ARE CURRENTLY TAKING:
INCLUDING OVER THE COUNTER MEDICATIONS

____
____
____
____

ALLERGIES

ASPIRIN________
CODEINE_______
ERYTHROMICIN_________
LOCAL ANESTHETIC______
PENICILIN______
LATEX__________

OTHER:
____
____
____
____

I HAVE READ ALL OF THE INFORMATION ON THIS SHEET AND HAVE COMPLETED THE ABOVE ANSWERS. I CERTIFY THIS INFORAMTION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY HEALTH STATUS.

____ ____
(SIGNATURE) (Parent or Guardian if patient is a minor) **(DATE)**

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATIONG ABOUT YOU MAY BE USED AND DISCLOSED WITHIN THIS ORGANIZATION AND HOW YOU CAN OBATIN ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

Dental Horizons of Westchester (DHW) is required by law to maintain the privacy of your personal medical/dental information.

Uses and Disclosures:

Treatment:
DHW may use your information to provide or coordinate your care. We may disclose all or any portion of your dental/medical information to any of our dentists, physicians, other consulting or referring dentists or physicians, nurses or nurse practitioners, physician assistants, and other employees who have a legitimate need for such information to provide or coordinate your care.

Payment:
We may release your information to determine coverage by an insurer for our services, billing and claims processing. The information may be released to an insurance company, third party payer or other organization involved in the payment of your bill. This information may include copies or excerpts of your dental/medical information that's necessary to receive payment.

Routine Operations:
We may use and disclose your information during routine operation of practice. An example of routine operations would be to contact you to remind you of an appointment or to disclose information to transcriptionist, attorneys, or consultants working for the practice. These entities are called "business associate". We require our business associates to treat your information in the same manner that we do

Regulatory Agencies:
We may use and disclose your information to state, local or federal agencies authorized by law to conduct inspections, audits, or investigations of the practice.

Law Enforcement/Litigation:
We may disclose your information for valid law enforcement purposes as required by law or in response to a court order or subpoena.

Public Health:
We may disclose your information to public health authorities by law and related to the prevention or control of certain diseases.

Workers Compensation:
We may release your information to Worker's Compensation agencies on the event your illness or injury may be related to work.

Military / Veterans:
If you are a member of the armed forces or a veteran, we may release your information as required by military command authorities.

As Otherwise Required:
We may disclose your information in any situation in which such disclosure is required by law (for example, child or domestic abuse)

Prohibited Uses:
We will not disclose your information to persons outside the practice for purposes other than treatment, payment, or healthcare operations without your authorization in writing. If you provide such an authorization to us, you may revoke it in writing at any time in the future and we will honor that request.

Your Rights Related to Your Health Information:
Although all records concerning your treatment at DHW you have certain rights concerning this information as follows:

Right to Confidentiality: You have the right to receive confidential communication of your health information by alternative means or at alternative locations, if you so request in writing.
Right to Inspect and Copy: You generally have the right to inspect and receive a copy of your health information from DHW unless law or your dentist restricts it. You will need to pay for copies of any records we provide.
Right to Amend: You have the right to request an amendment or correction to your health information. If we agree that information is appropriate, we will include that information in your dental/medical record.
Right to Accounting: You have the right to obtain a record of disclosure that we make of your health information for other than treatment, payment or routine operation of the practice.
Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your health information. We will abide by these requests to extent that we are able.
Right to Revoke Authorization: You have the right to revoke your prior authorization to release your health information except to the extent action was taken in reliance of your original authorization.
Right to Complain: you have the right to formally complain about our handling of your health information. You may contact the practice administrator below or the Department of Health and Human Services. If you complain, we will not retaliate against you in any way.

For more information regarding this policy please contact us at 914-939-3413

Changes to this Notice: DHW will abide by the terms of the Notice currently in effect. However DHW reserves the right to change the terms of the Notice at any time. Any new notice provisions will be effective for all health information from the time that the changes are effective within.

Effective Date of this Notice: January 21, 2014

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

(After review of this document, please sign and return to front desk)

I,______________________________________ , hereby acknowledge that I have received and reviewed the “Notice of Privacy Practices” which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and healthcare operations.

____
Signature of Patient or Patients Representative

____
Date

____
Printed Name of Patient or Patients Representative

____
If Representative, Specify Relationship

Puja Taneja DDS
388 Westchester Avenue Suite 1M
Port Chester, NY 10573
Ph: 914-939-3413   Fax: 914-939-0041

CANCELLATION POLICY

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least **36 hours** in advance.

As of January 1, 2016 there will be a fee of $25.00 assessed if we do not receive a call to cancel an appointment.

Please sign this form after you have read it.

Name:______________________________

Signature:___________________________

Date:_______________________________

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy.