MADALYN DAVIDSON DMD

NOTICE OF PRIVACY POLICIES

Health Insurance Portability Accountability Act (HIPAA), 1996
http://www.hhs.gov/ocr/hipaa/finalreg.html

Name: _____ Phone: _____

Address: _____

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

YOUR RIGHTS
You have the right to have access and/or copies of your PHI records at any time. You have the right to request additional restrictions on your PHI, and we will do so unless legally bound otherwise. You have the right to refuse to sign the consent form, or to rescind your consent.

_____
Signature

FOR OFFICE USE:
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 (Specify) _____

MADALYN DAVIDSON DMD

ABOUT YOU

Today's Date: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____

SS #: _____

Birthdate: _____ Age: ____ ☐ Male ☐ Female ☐ Gender Neutral

Home Address: _____
APT/CONDO #:

_____
CITY STATE ZIP

Cell #: _____

E-mail Address: _____

How do you prefer to be contacted? ☐ E-Mail ☐ Phone ☐ Text

Employer: _____

Occupation: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

How did you find out about us? ☐ Friend ☐ Google ☐ ZocDoc ☐ Yelp ☐ Facebook ☐ Other

Whom may we Thank for referring you? _____

INSURANCE COVERAGE

Primary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID #: _____

Insured's Employer: _____

Secondary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID #: _____

Insured's Employer: _____

SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

SS #: _____ Birthdate: _____

Person Responsible for Account: _____

Cell: _____ Employer: _____

Billing Address: _____

Relation: _____ SS #: _____

EMERGENCY CONTACT

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Wk #: _____ Cell #: _____

CONTINUED ON BACK

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one: _____

_____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

For Women: Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

- ☐ Abnormal Bleeding
- ☐ Alcohol / Drug Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Bones/Joints/Valves
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer/Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes / Fever Blisters
- ☐ High Blood Pressure
- ☐ HIV+ / AIDS
- ☐ Hospitalized for Any Reason
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic / Scarlet Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease / Traits
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Jewelry
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Tetracycline

Please list any other drugs/materials that you are allergic to:

_____

_____

DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No Fresher breath? ☐ Yes ☐ No

How many times a week do you floss? a day do you brush?

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ Date _____

Signature

Payment is due in full at the time of treatment unless prior arrangements have been approved.

I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover.

_____

Signature Date

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

INTERNAL USE

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

MADALYN
DAVIDSON
DMD

212 W 15th St
New York, NY 10011
212 597 2457

FINANCIAL AGREEMENT

Welcome to our practice. We appreciate that you have chosen us for your oral care and will strive to meet your treatment needs promptly and efficiently.

Full payment is expected at time of service. We offer several payment options:

- Cash, checks, and major credit cards are accepted
- Extended payment plans up to 6 months may be arranged with prior approval
- Care Credit is also available and accepted

Dental Insurance

Your insurance coverage may or may not include benefits for various treatments. Benefits are dictated by the terms of your or your employer's contract with the insurance carrier. Plans vary enormously even within the same company in levels of reimbursement, excluded services, deductibles, maximum annual or lifetime benefits, and terms of payment. Few insurance plans cover all fees. Many provide partial coverage. Some specifically exclude some or all periodontal services, orthodontics, occlusal guards, and/or implants.

Regardless of coverage, the patient, not the insurance company, is ultimately responsible for fees incurred in this office.

My staff will assist you in submitting the necessary forms for insurance reimbursement. We usually file a pre-estimate, and the insurance company generally requires X-rays, periodontal charting, intra-oral photos, and a detailed treatment plan. Completed treatment forms are typically submitted after your Estimate of Benefits has been returned to us and treatment has been performed. Questions regarding the terms of your coverage or delays in payment should be directed to your insurance carrier by you or your employee benefits administrator.

NOTE: For all surgical cases, a 50% deposit is required when your appointment is made. (Surgical cases include but are not restricted to extractions, bone grafting, and implants). Balance is due at the time of the surgical procedure unless other financial arrangements have been made. For all orthodontic cases, such as invisalign, there is a deposit required to start treatment.

I understand that I am personally responsible for all fees incurred in this office.

Signature _____ Date _____

I authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when appropriate, to other providers rendering medical/dental care.

Signature _____ Date _____