Schwartz Family Dentistry Patient Information Up to 18 Years Old

Name_____ **Date of Birth**____/____/____

Address_____ **Home Phone**_____

City_____ **State**____ **Zip**_____ **Cell Phone**_____

Guardian Information:

Mother's Name_____ **Contact Phone**_____

Date of Birth____/____/____

Address (if different than above)_____

Father's Name_____ **Contact Phone**_____

Date of Birth____/____/____

Address (if different than above)_____

Legal Guardian's Name _____ **Contact Phone**_____

Address (if different than above) _____

Patient Resides with _____**both parents**_____ **mother only**_____ **father only**_____ **legal guardian**

Dental Insurance Information:

Primary Dental Insurance_____ **ID#**_____

Subscriber Name_____ **DOB**_____

Employer_____ **Group #**_____

Secondary Dental Insurance_____ **ID#**_____

Subscriber Name_____ **DOB**_____

Employer_____ **Group #**_____

Office Policies:

-You are responsible for payment in full at the time services are rendered.
-We accept cash, checks, Visa, Mastercard and Discover credit cards.
-There is a $30.00 NSF Service Fee for all returned checks.
-We offer payment plans to fit your budget. All payment plans must be agreed upon prior to the date of service. Please call the office manager to discuss these options.
- If your account balance becomes 60 days past due, and you have not contacted our office regarding the past due amount, the amount will be charged to your credit card or begin to accrue interest on your account at 18% APR-
- We set aside time for our patients by scheduling appontments. If an appointment is cancelled without adequate notice or broken without notice at all, it prevents others from scheduling appointments. If an appointment is cancelled without at least 24 hours notice, or broken without a 24 hour notice, a missed appointment fee of $50 will be charged to your account at our discretion. You may call our office to cancel an appointment 24 hours a day, seven days a week.

Signature_____ Date_____

Patient Medical History

Patient Name: _____

Primary Care Physician: _____ Phone# _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have and important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

		If yes, please explain
Are you under a physicians care now other than routine ?	O Yes O No	
Please list any medications, pills, or drugs you are taking ?	O Yes O No	
Are you under a cardiologist's care? If YES, please provide the name and phone number of doctor.	O Yes O No	
Are you taking any over the counter/herbal supplements ?	O Yes O No	
Have you ever had a total joint replacement ?	O Yes O No	
Do you have any known allergies ?	O Yes O No	
What is the name and phone number of your preferred pharmacy ?	O Yes O No	
Are you currently on a blood thinner ?	O Yes O No	
Have you ever taken bone density medications containing bisphosphonates ? (Fosaman, Boniva, Actone)?	O Yes O No	

Women: Are you... ○ Pregnant/Trying to get Pregnant ? ○ Nursing ? ○ Taking oral contraceptives?

AIDS/HIV Positive	O Yes O No	Diabetes Type 1	O Yes O No	Hepatitis B	O Yes O No	Osteoporosis	O Yes O No
Alzheimer's Disease	O Yes O No	Diabetes Type 2	O Yes O No	Hepatitis C	O Yes O No	Pain in Joints	O Yes O No
Anemia	O Yes O No	Drug Addiction	O Yes O No	High Blood Pressure	O Yes O No	Parathyroid Disease	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No	High Cholesterol	O Yes O No	Psychiatric Care	O Yes O No
Arthritis/Gout	O Yes O No	Epilepsy or Seizures	O Yes O No	Hives/Rash	O Yes O No	Radiation Treatments	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes O No	Irregular Heartbeat	O Yes O No	Renal Disease	O Yes O No
Blood Disease	O Yes O No	Fainting/Dizzy Spells	O Yes O No	Kidney Problems	O Yes O No	Rheumatism	O Yes O No
Blood Transfusion	O Yes O No	Hearing Impairment	O Yes O No	Leukemia	O Yes O No	Sinus Trouble	O Yes O No
Breathing Problems	O Yes O No	Hear Attack/Failure	O Yes O No	Liver Disease	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Cancer	O Yes O No	Heart Murmur	O Yes O No	Low Blood Pressure	O Yes O No	Stroke	O Yes O No
Chemotherapy	O Yes O No	Heart Pacemaker	O Yes O No	Lung Disease	O Yes O No	Swelling of Limbs	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Heart Trouble/Disease	O Yes O No	Memory Loss	O Yes O No	Thyroid Disease	O Yes O No
Congenital Heart Disorder	O Yes O No	Hemophilia	O Yes O No	Mitral Valve Prolapsed	O Yes O No	Tuberculosis	O Yes O No
Convulsions	O Yes O No	Hepatitis A	O Yes O No				

Have you ever had any serious illness not listed above ? O Yes O No **If yes, please explain** _____

_____

_____

Comments: _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered, I understand that providing incorrect information can be dangerous to my (or Patient's) health. It is my responsibility to inform he dental office of any changes in medical status.

Signature of Patient, Parent or Guardian"

Signature X _____ Date: _____

KENNETH
SCHWARTZ
DDS
family dentistry

833 UNION STREET
SCHENECTADY
NEW YORK 12308
518.374.1935

Minor Treatment Consent Form

I, _____ give my permission to the staff of Kenneth D.
legal guardian/parent

Schwartz DDS to perform the following (checked) dental services on

_____, a minor I am legally responsible for.

_____ _____
legal guardian/ parent **date**

fillings_____ **cleaning_____** **bitewings_____**

full mouth x-ray_____ **fluoride treatment_____**

FINANCIAL AND OFFICE POLICIES

At Schwartz Family Dentistry, we are committed to providing you with personal care. We ask that you carefully read and sign this statement, which outlines our policies regarding payment, insurance claims and scheduling.

Payment:

You are responsible for full payment at the time of services. Full payment may include partial coverage from your insurance carrier, but the details must be arranged prior to treatment. We accept cash, check, Visa, MasterCard, and Discover. THERE IS A $30 SERVICE CHARGE FOR ALL RETURNED CHECKS!

Payment Plans:

We offer short term payment plans. These must be prearranged and require a credit card number to insure against payment delinquency. We require half of the total balance down and the remainder bill must be paid within 6 months. Outstanding balances for more than 60 days acquire a 1.5% finance charge monthly until the balance is paid off.

Insurance Coverage:

It is your responsibility to know the definition of your unique insurance plan. Please understand that your insurance coverage is an agreement between you, your employer and your insurance company. We are NOT part of this contract. We "participate" with many carriers meaning we will accept payment directly from them. Participate does NOT mean that we automatically accept their reimbursement portion as full payment. Depending on your individual coverage you may have a patient obligation.

Please be aware that insurance policies and claims DO NOT always cover full payment – THE REMAINING BALANCE IS YOUR RESPONSIBILITY!

GHI Participants:

Please note that Group Health, Inc does not accept assignment of benefits from us. Full payment is required to our office for treatment on the date of service. Our office will submit the claim to GHI and the patient will then be reimbursed according to their individual coverage.

Missed Appointments:

Patients must call within 24 hrs. to cancel or reschedule appointments. If you fail to do so, a $25 missed appointment fee will be added to your account.

I have read the above and understand and agree to this policy.

Name _____

Signed _____

Date _____

Schwartz Family Dentistry
833 Union Street
Schenectady, NY 12308

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE AND DISCLOURE FOR TREATMENT, PAYMENT, AND OPERATIONS PURPOSES

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by this office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of this office.

I hereby authorize the following person(s) to have access to information covered under the privacy practices regarding myself. Please include their relationship to you and their contact information.

_____

_____

_____

Signature:_____ Date: _____

Affective date of notice: April 9, 2004

NOTICE OF PRIVACY PRACTICES

Kenneth D. Schwartz, D.D.S.
833 Union St.
Schenectady, New York 12308
(518) 374-1935
(518) 374-1982
Office Manager: Nicole Tiscione

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

If you wish that we ask for special written permission to disclose your health information outside of our office for the above reasons, you may request that we do so by contacting the office manager, in writing at the above address.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic

violence;

- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;
- other uses and disclosures as affected by New York State Law.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office manager at the above address.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to

the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office and have copies available in our office.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office manager at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office manager at the address or phone number shown at the beginning of this Notice.