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
legal guardian/parent (please print name)

staff of Kenneth D. Schwartz DDS PC to perform the following dental services (checked below) on _____, a minor I am
please print name

legally responsible for.

_____ _____
Signature of legal guardian/parent date

Procedures approved:

fillings _____ cleaning____ bitewing x-rays____

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 $35.00 SERVICE CHARGE FOR ALL RETURNED CHECKS.**

Payment Plans:

We offer short term payment plans for established patients. 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 bull must be paid withing 6 months. Outstanding balances for more than 60 days acquire a 1.5% finance charge monthly until the balance is paid in full.

Insurance Coverage:

It is your responsibility to know the definition of your unique insurance plan. Please understand that your insurance coverage is 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 we will automatically accept their reimbursement portion as full payment. **Depending on your individual coverage you may have a different patient obligation than is estimated at time of service.** Insurance policies and claims **DO NOT** always cover full payment. **THE REMAING BALANCE IS YOUR RESPONSIBILITY.**

GHI Participants:

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

Missed Appointments:

Patients must call within 24 hours to cancel or reschedule appointments. If you fail to do so, a $35.00 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
(518) 374-1935

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE AND DISCLOSURE FOR THE 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:_____

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 April 14, 2003, 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.

For more information about our privacy practices, or to request a copy of our Notice, please contact us using the information listed on this website.

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, 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. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

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, 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 website 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 at the address or phone number provided on this website.

If you are concerned that we may have violated your privacy rights, 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 on this website. 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.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002; April 30, 2009).