PATIENT INFORMATION (Please Print front and back)

Today's Date_____/_____/_____

Patient DOB_____/_____/_____ Age_____

Patient Name (First, MI, Last) _____

Patient Mailing Address_____

City, State, Zip code_____

Cell or Home number (_____) _____-_____

Work number (_____)_____-_____

Email Address_____

How did you hear about us?_____

PRIMARY DENTAL INSURANCE/RESPONSIBLE PROVIDER

Member's Name_____

DOB_____/_____/_____

Member's Employer_____

Member SS# or ID#_____

Members Address_____

City, State, Zip Code_____

Insurance Co Name_____

Insurance Co Address_____

City, State, Zip code_____

Contact number (_____) _____-_____

Insurance: We do not participate with any insurance company, although we will work hard to help you receive your maximum benefit allowed under your plan. As a courtesy, we will file your claim(s) for a prompt reimbursement.

ADDITIONAL INSURANCE INFORMATION

Secondary Insurance will be submitted once the primary insurance plan has paid and there's proof of reimbursement amount. Please fill out if there is a secondary plan.

SECONDARY DENTAL INSURANCE

Member's Name_____

DOB_____/_____/_____

Member's Employer_____

Member SS# or ID#_____

Members Address_____

City, State, Zip Code_____

Insurance Co Name_____

Insurance Co Address_____

City, State, Zip code_____

Contact number (_____) _____-_____

APPOINTMENT POLICY

Once an appointment has been scheduled, please remember that this time has been reserved exclusively for you. Since your care is our utmost concern and your time is as valuable as ours we do expect 24hrs notice if you need to cancel or reschedule the appointment. If an appointment is missed or cancelled without prior notification of at least 24hrs you may be subject to a $15.00 per 15 minutes of scheduled time. Thank you for your consideration.

Patient Signature_____ **Date**_____

Financial Options

Our office policy is payment due at the time of service. We accept cash, check, and all major credit cards including care credit. If you have dental insurance please discuss with our staff about future visits. Please initial next to the payment option(s) you will be using.

I, _____, choose the following payment for my dental visit(s) along with any other dependents.

_____ CASH

_____ CHECK

_____ MASTER CERD

_____ VISA

_____ DISCOVER

_____ AMEX

_____ CARE CREDIT

_____ INSURANCE/FLEXIBLE SPENDING (Only if approved by our office manager)

Patient Signature_____ **Date**_____

MEDICAL HISTORY REVIEW PAST & PRESENT

Patient Name:_____ DOB_____

Emergency Contact Name:_____

Relationship: _____

Contact Number(s)_____ _____

Current Medical Dr & Number _____

Specialist Doctors name & Number _____

Pharmacy name and number _____

Medical
Condition(s)_____

_____

_____

_____

Current
Medication(s)_____

_____

_____

_____

Medical
Allergies_____

_____

_____

_____

Hospitalization(s)_____

_____

_____

Patient Signature_____Date:_____

PATIENT HEALTH INFORMATION

Today's Date ____/____/____

Patient Name _____
Birthdate ____/____/____

It is important that we know about your medical and dental history. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone without your prior approval. Thank you for taking the time to completely fill out this form.

DENTAL HISTORY

Are you anxious about dental care? _____
How long since your last dental visit? _____
Last COMPLETE dental exam. Date _____
Are you having problems now? _____
What are they? _____
_____

Circle Each YES Response

1. Do you have any of the following:
   - Broken / rough fillings
   - Decayed teeth
   - Bleeding, irritated gums
   - Missing teeth
   - Loose teeth
   - Jaw or joint pain
   - Clicking / popping jaw joint
   - Pain / ringing in the ears
   - Food catches between teeth
2. Are your teeth sensitive to hot or cold?
3. Are your teeth sensitive to sweets, pressure?
4. Are you aware of grinding/clenching of your teeth?
5. Do you have headaches, earaches, or neck pains?
6. Have you worn braces on your teeth?
7. Are you unhappy with the appearance of your teeth?
8. Do you have discolored teeth that bother you?
9. Do you regularly use dental floss?
10. Would you like your smile to look better or different? How do you feel about your teeth?

_____
_____

Please RANK the following in the order in which they would keep you from having dental treatment? (Use 1 through 4) 1= Least likely to keep you from treatment; 4= Most likely.

FEAR of pain
COST of treatment
LACK of concern
MISSING work time

Name of Previous Dentist _____
City, State _____
Phone _____

MEDICAL HISTORY

Do you have any current health problems?
_____
Are you under a physician's care now? _____
For what? _____
What medications are you currently taking?
_____
Are you pregnant? _____
Do you smoke? _____

Circle any of the following which you have had or presently have:

- Heart Disease or Attack
- Angina Pectoris
- Tuberculosis TB
- High Blood Pressure
- Heart Murmer
- Rheumatic Fever
- Congenital Heart Lesions
- Mitral Valve Prolapse
- Artificial Heart Valve
- Sinus Trouble
- Heart Pacemaker
- Heart Surgery
- Nervousness
- Artificial Joints: Hip, Knee
- Stroke
- Cortisone Medication
- Pain in Jaw Joints
- AIDS / HIV positive
- Hepatitis A (Infectious)
- Hepatitis B (Serum)
- Emphysema
- Liver Disease
- Blood Transfusion
- Drug Addiction
- Hemophilia
- Fever Blisters
- Ulcers
- Epilepsy / Seizures
- Thyroid Disease
- Radiation Treatment
- Psychiatric Treatment
- Anemia
- Chemotherapy
- Kidney Trouble
- Venerial Disease (Syphilis, Gonorrhea, Etc.)
- Cosmetic Surgery
- Hay Fever
- Allergies
- Arthritis
- Alcoholism
- Bruise Easily
- Asthma
- Diabetes
- Glaucoma

Are you allergic to or have you REACTED ADVERSELY to any of the following medications?

- Local Anesthetic
- Nitrous Oxide
- Penicillin
- Erythromycin
- Aspirin
- Codeine

Are you allergic to any other medications or substances? _____
If yes, please list: _____

Family Physician _____
Telephone _____

To the best of my knowledge, the medical and dental history presented are true and correct. I will notify this office of any change in health or medication

Signature _____

Advanced Dental Technology OF ITHACA II, PLLC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____ _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is displayed in our office.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Advanced Dental Technology of Ithaca II, PLLC
1301 Trumansburg Road, Suite S, Ithaca, New York 14850
(607) 273-5940 • FAX (607) 273-4625

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____ , have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____
Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

Advanced Dental Technology of Ithaca II, PLLC
HIPAA AUTHORIZATION

Please list anyone that you authorize us to share your private health information with:
(Parent, spouse, significant other, etc.)

Name:_____ Name: _____
Address:_____ Address: _____
City/State/Zip:_____ City/State/Zip:_____
Phone: _____ Phone: _____
Relationship: _____ Relationship: _____

Please select below how we may communicate with you regarding your private health appointment information. *Certain messages may contain medical information (i.e. diagnostics or prescriptions) or can be more generic in nature (i.e. appointment reminders or rescheduling).*

I consent to have staff inform me or authorized individuals above using the following methods, please check all that apply:

Private Health Information
☐Home/Ans Machine ☐Cell Phone ☐Office/ Voicemail ☐Another Person ☐Mail ☐Email

Non-Medical Information
☐Home/Ans Machine ☐Cell Phone ☐Office /Voicemail ☐Another Person ☐Mail ☐Email

Expiration Date of Authorization: This authorization is effective indefinitely unless revoked or terminated in writing by the patient or the patient's legal guardian. This authorization automatically revokes when minor child reaches 18.

_____ _____
Name of Patient (Print or Type) Date of Birth

_____ _____
Signature of Patient, Parent or Guardian Today's Date

_____
Relationship of Patient Representative to Patient

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION
You may revoke or terminate this authorization by submitting a written revocation to Advanced Dental Technology of Ithaca II, PLLC.

RIGHTS OF THE INDIVIDUAL
* You may inspect or copy information used or disclosed under this authorization.
*You may refuse to sign this authorization.

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, have copies available in our office, and post it on our website.

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 written complaint to the office contact person 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 contact person at the address or phone number shown at the beginning of this notice.

----------TEAR HERE----------TEAR HERE----------

Acknowledge of receipt

I acknowledge that I received a copy of Dr. Marcia Zax Notice of Privacy Practices.

Patient name_____

Patient signature_____

Guardian signature_____

Date_____

Record Release Authorization

To:_____

_____

_____

_____

I_____DOB_____

hereby authorize the release of my dental records. This includes all chart notes and ALL dental x-rays. Thank you.

Signature: _____ Date: _____

Please send to: Advanced Dental Technology of Ithaca II, PLLC

Marcia S. Zax, DDS, PhD

1301 Trumansburg Rd Suite S

Ithaca, NY 14850

Digital images drzax@aspidamail.com

(607)273-5940

(607)273-4625 Fax