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

Patient Name: ________________________________Date of Birth:_______________________

LOCAL Emergency Contact Name and telephone #:____________________________________

Relationship to Emergency Contact ____

Medical Doctor Name and #:____

Specialist Doctors name(s) and #(s):____

Pharmacy Name and Number:____

Medical Conditions: Circle any you have had:

Vaccination COVID 19 – Moderna, Pfizer, Johnson and Johnson Dates:

Heart: High Blood Pressure, Congestive Heart Failure, Angina, Stroke, Heart Attack, Pacemaker, Heart Surgery, Congenital Heart Problem, Mitral Valve Prolapse, Artificial heart Valve, Other

Respiratory: Asthma, Emphysema, Tuberculosis, Sinus allergies, Other

Tobacco History: Cigarettes, cigars, Snuff

Frequency of Use: daily, weekly, monthly

Stomach Disease: Ulcers, Irritable Bowel, Celiac, Other

Kidney Disease: stones, other

Liver Disease: Hepatitis A, Hepatitis B, C or other

Thyroid Problem: Hypothyroid, Hyperthyroid (Hashimoto's), Other

Diabetes: Insulin Dependent, non-insulin dependent

Eye Disease: Glaucoma, Other

Epilepsy, Seizures, Cancer, Chemotherapy, Radiation, Arthritis, Joint Pain, Blood Transfusion, AIDS/HIV, Alcoholism, Drug Addiction, Venerial Disease, Anemia, Bruise Easily, Hemophilia, Anxiety, Nervousness, Psychiatric Treatment

Medications: (Please bring typed list)

____

____

Medical Allergies:____

Hospitalizations:____

Dental History:

Previous Dentist:____

City, State:____

Telephone and Email:____

Last Complete Dental exam and exrays:_______________________________________

Current Dental Concern:____

Do you have any of the following (circle for yes):

Broken or rough fillings, decayed teeth, bleeding gums, loose teeth, jaw or joint pain, clicking or popping jaw joint, pain/ringing in ears, food catching between teeth

Are your teeth sensitive to hot, cold, sweets, or pressure?

Do you grind or clench your teeth?

Please rank the following in the order in which they would keep you from having dental treatment on a scale from 1 to 4. 1=least likely to keep you from treatment and 4=most likely

Fear of pain, Cost of treatment, Lack of concern, Missing work time

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.

NOTICE OF PRIVACY PRACTICES

Effective date of notice: July 8, 2013

Marcia S. Zax, DDS, PhD

Advanced Dental Technology

Of Ithaca, II PLLC

1301 Trumansburg RD, Suite S

Ithaca, NY 14850

Phone (607) 273-5940

Fax (607) 2734625

drzax@aspidamail.com

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 to use or disclose information of treatment purposes are: setting up an appointment for you; examining your teeth, mouth, and oral health; prescribing medications and faxing them to be filled; prescribing dental appliances and dental prostheses; showing you treatment options; referring you to another dentist for specialty care; 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 dental or medical 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 proposes without any special permission. If we need to disclose your health information outside of our office for these reasons, [we usually will not] ask for special written permission. [We will ask for special written permission in the following situations: anything related to HIV/AIDS status].

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;
- Disclosure 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;
- Disclosure 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 and 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 the evaluation and health of members of the foreign service;
- Disclosures of de-identified information;
- Disclosure relating to a worker’s compensation programs;

Disclosures of “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 preform health care operations for us and who commit to respect the privacy of your health information.

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 treatment or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a postcard, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you're 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 contact person named at the beginning of this notice.

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. We must honor a restriction not to send information to a health care plan regarding any service for which you already made full payment. To ask for a restriction, send a written request to the 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 E mail to your personal E mail address. We will accommodate these requests if they are reasonable. If you want to ask for confidential communications, send a written

request to the 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 10 days of asking us. 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. 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, E mail at the beginning of the 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 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 reason for the amendment, to our 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 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 to the office contact person at the address, fax, or E mail shown at the beginning of this notice.

Be notified by us in a timely manner of any breach of the privacy and confidentiality of your unsecured protected health information, which we will provide to you in accordance with law and take all appropriate measures to address.

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

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