

WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum

oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

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ABOUT YOU

Today's Date: _____

E-mail Address: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ M ☐ F ☐ Non-binary

Birthdate: ____/____/____ Age: ____ SS #: _____

Home Address: _____
APT/CONDO #: _____

CITY STATE ZIP
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____) Cell #: (____)

Wk #: (____) Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? ____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

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SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Contact #: (____) Ext: ____ SS #: _____

Birthdate: ____/____/____ Driver's License #: _____

Person Responsible for Account: _____

Contact #: (____) _____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

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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: _____

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

His / Her Name: _____ Relation: _____

Wk #: (____) Hm #: (____)

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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: _____

CONTINUED ON BACK

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MEDICAL HISTORY *continued*Your current physical health is: ☐ Good ☐ Fair ☐ PoorAre 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 ☐ NoHave you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ NoFor Women: Are you using a prescribed method of birth control? ☐ Yes ☐ NoAre you pregnant? ☐ Yes ☐ No Week #: _____Are you nursing? ☐ Yes ☐ No

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

<input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis
<input type="checkbox"/> Y <input type="checkbox"/> N Alcohol / Drug Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N Herpes / Fever Blisters
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure
<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N HIV+ / AIDS
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves	<input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized for Any Reason
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Autism	<input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure
<input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N Lupus
<input type="checkbox"/> Y <input type="checkbox"/> N Colitis	<input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse
<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect	<input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker
<input type="checkbox"/> Y <input type="checkbox"/> N Covid-19	<input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Treatment
<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment
<input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever
<input type="checkbox"/> Y <input type="checkbox"/> N Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N Seizures
<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N Shingles
<input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells	<input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits
<input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke
<input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB)
<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Ulcers
<input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery	<input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia	

Have you received vaccination for Covid-19? ☐ Yes ☐ No

Type? _____ Date(s)? _____

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

Are you allergic to any of the following?

<input type="checkbox"/> Y <input type="checkbox"/> N Aspirin	<input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin	<input type="checkbox"/> Y <input type="checkbox"/> N Metals
<input type="checkbox"/> Y <input type="checkbox"/> N Codeine	<input type="checkbox"/> Y <input type="checkbox"/> N Jewelry	<input type="checkbox"/> Y <input type="checkbox"/> N Penicillin
<input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics	<input type="checkbox"/> Y <input type="checkbox"/> N Latex	<input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline

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

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DENTAL HISTORY

Why have you come to the dentist today?

Do you require antibiotics before dental treatment? ☐ Yes ☐ NoAre you currently in pain? ☐ Yes ☐ No Do your gums ever bleed? ☐ Yes ☐ NoHave you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ NoDo you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ NoYour current dental health is: ☐ Good ☐ Fair ☐ PoorDo you like your smile? ☐ Yes ☐ NoWould 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 ☐ HardDo 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.

Signature _____

Date _____

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



If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment 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.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

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

Doctor's Comments: _____

MEDICAL HISTORY UPDATE

1. Date: _____ Comments: _____ Signature: _____

2. Date: _____ Comments: _____ Signature: _____

3. Date: _____ Comments: _____ Signature: _____

SOMERS DENTAL CARE
Dr. Paul Harbottle, DDS
380 Route 202
Somers, NY 10589
914-277-3518

HIPAA & Notice of Privacy Practices

PATIENT DETAILS

First Name*

Last Name *

Date of Birth *

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES (THE "NOTICE") DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

OUR LEGAL DUTY

As a recipient of health care services, you have certain rights. To learn more about these rights, we suggest you visit: <https://www.hhs.gov/hipaa/for-individuals/index.html>. We are required by 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 will follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time. 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 make commercially reasonable efforts to change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

OUR USE AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you only as necessary for treatment, payment, and our 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.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations including without limitation, quality assessment and improvement activities, reviewing the competence or qualifications of Health care 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 health care 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 a written authorization, you may revoke it in writing at any time, although such revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or intentionally 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 health care or with payment for your health care, but only if you agree in writing 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, concerning 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 (1) 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 health care and (2) use our professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing third parties to pick up 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 may be a victim of abuse, neglect, or 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 institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders.

PATIENT RIGHTS

Access: You have the right to review or obtain copies of your health information, with limited exceptions. You may request 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. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.

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, health care operations and certain other activities, for the last 6 years. We will provide such a list at no charge upon your request once in any 12 month period. We reserve the right to charge you for requests in excess of one per 12 month period.

Restrictions: 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. (Any such 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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form upon your request.

QUESTIONS AND COMPLAINTS

To learn more about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or 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 contact us using the contact information listed below. 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.

Acknowledgement: I hereby acknowledge that I have read and fully understand the contents of this document, and I have been given the opportunity to ask any and all questions.

If patient is a minor,

Guardian's relationship to patient: _____

***By signing below, I acknowledge that I have read and understand this practices Notice of Privacy Practices**

Patient Signature: _____ x

Date: ____/____/____