Maple/ Stoney Brook
Family & Cosmetic
Dentistry

New Patient Registration

Patient Information			
Last Name	First Name	MI	circle Male / Female
Birth Date	Social Security #	Circle Married Single Child	
Street Address	City	State	Zip
O Cell Phone	O Home Phone	O Work Phone	
Email Address			

Please check the phone number above that is your preferred daytime contact number.

Responsible Party O (check if same as above)			
Last Name	First Name	MI	circle Male Female
Birth Date	Social Security #	Circle Married Single Child	
Street Address	City	State	Zip
O Cell Phone	O Home Phone	O Work Phone	
Email Address			

Please check the phone number above that is your preferred daytime contact number.

Insurance Policy Holder Information (Primary)			
Last Name	First Name	MI	circle Male Female
Birth Date	Social Security # or Insurance ID #	Policy Holder relationship to Patient	
Street Address	City	State	Zip
O Cell Phone	O Home Phone	O Work Phone	
Email Address			
Policy Holder Employer	Insurance Company Name	Group Number	

Secondary Insurance Information

Last Name	First Name	MI	circle Male Female
Birth Date	**Social Security # or Insurance ID #**	**Policy Holder relationship to Patient**	
Street Address	**City**	**State**	**Zip**
O Cell Phone	O Home Phone	O Work Phone	
Email Address			
Policy Holder Employer	**Insurance Company Name**	**Group Number**	

Release

I.) I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administratering claims for insurance benefits.

II.) I hereby authorize payment of insurance benefits directly to Maple or Stoney Brook Dental, otherwise payable to me.

III.) I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill of services. I understand that I am financially responsible for payment in full for all accounts that I am responsible for as listed in the financial policy (NPFORM2). By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

IV.) I attest to the accuracy of the information on this page.

______________________________________ ________________

Signature of Patient/ Responsible Party 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 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 you health information and what rights you have regarding it.

Your Authorization: In addition to our use of your health information for the following purposes, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. I you give us an 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.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes:

Treatment: We may use or disclose your health information for your treatment. For example, we may 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 information to obtain payment for services we provide to you. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To You of Your Personal Representative: 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 your personal representative, 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 location) 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 absence or incapacity or in 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.

Disaster Relief: We may use of disclose your health information to assist in disaster relief efforts.

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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who

may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 institutional law enforcement official having lawful custody the protected health information of an inmate or patient under certain circumstances.

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.

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 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, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003.

Restriction: You have the right to receive a list of instances in which we or our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure if required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying our payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information 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 complain to our office. 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.

I acknowledge that I received a copy of Maple/ Stoney Brook Dental's Notice of Privacy Practices.

Patient Name ____

Signature______________________________ **Date** ______________________

Financial Policy

Maple/ Stoney Brook Family & Cosmetic Dentistry

In order to provide you with the highest quality dental care, we provide our patients with estimates of all fees. Patient, parent and/or guardian will be responsible for the patient portion on the date of service.

Financial options that we provide at this time:

Cash or check on date of service

Major credit cards: American Express, Visa, MasterCard, Discover

Extended Financial Arrangements: (based on credit approval)

Verbal Agreement Payment Strategy: (based on payment history)

Care Credit: Up to two years interest-free financing

Account balances that are 90 days overdue will be charged a finance charge of 3% of the total unpaid balance monthly until balance is paid in full.

It is your responsibility to complete treatment and follow your recommended maintenance schedule. If the treatment and maintenance plans are not followed and/or appointments are missed, adverse results could affect your dental health. If you do not proceed with your treatment plan in a timely manner, further treatment for that involve teeth, supporting tissues, Jason and opposing teeth, and muscles or joints can be affected.

Appointment commitment

We appreciate you choosing us to meet your dental needs. We take this responsibility seriously and have qualified staff ready to accommodate you during your reserved appointment time.

Please review the following:

If circumstances occur and it is necessary to change your appointment, we request that you give us at least 24 hours' notice from the scheduled time of your appointment. A broken appointment, one in which a patient does not call or show up, is not acceptable if you have scheduled an appointment and do not show up or call, it may be necessary for you to come into the office personally and schedule any future appointments.

There will be a room set up fee charged for a missed appointment, per provider. For the first missed appointment fee is $25, second missed appointment fee is $50, third missed appointment fee is $100.

I understand and agree to the after mentioned, and I promise to pay any/all remaining balance on my account.

______________________________ ______________

Signature of responsible party Date

Stoney Brook / Maple Brook Dentistry

Date

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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 an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question		If yes
Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

- Pregnant/Trying to get pregnant?
- Nursing?
- Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin
- Penicillin
- Codeine
- Acrylic
- Metal
- Latex
- Sulfa Drugs
- Local Anesthetics

Other? If yes

Do you use controlled substances? Yes No If yes

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
						Yellow Jaundice	Yes No

Have you ever had any serious illness not listed Yes No If yes

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 the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:__________