ROCKLAND DENTAL GROUP, P.C.

238 North Main Street • New City, NY 10956
(845) 634-8900

Patient Personal Information

Title _____ Nickname _____ Birth Date _____ Age _____
Last, First _____ Marital Status _____ Sex _____
Address _____ Home # _____ Work # _____
_____ Cell # _____ Drive Lic _____
City, State, Zip _____ Student _____ SSN _____
Email _____ School Name _____
_____ Referral Type _____

Person responsible/guarantor for paying bills

Title _____ Nickname _____ Birth Date _____ Age _____
Last, First _____ Marital Status _____ Sex _____
Address _____ Home # _____ Work # _____
_____ Cell # _____ Drive Lic _____
City, State, Zip _____ SSN _____
Email _____

Do you have Primary Dental Insurance? Yes No

Group No/Name _____
Insurance Name _____
Phone # _____
Employer Name _____
Subscriber Last, First _____
Subscriber Address _____
City, State, Zip _____
Relationship to Patient _____ Birth Date _____
Subscriber ID _____

Do you have Secondary Dental Insurance? Yes No

Group No/Name _____
Insurance Name _____
Phone # _____
Employer Name _____
Subscriber Last, First _____
Subscriber Address _____
City, State, Zip _____
Relationship to Patient _____ Birth Date _____
Subscriber ID _____

Patient Medical Information

Allergic To

- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Barbiturates / Sleeping Pills
- ☐ Y ☐ N Codeine / Other Narcotics
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Gluten
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Metals
- ☐ Y ☐ N No Epinephrine
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Tetracycline
- ☐ Y ☐ N Other

Check, if applicable

- ☐ Y ☐ N AIDS/HIV Infection
- ☐ Y ☐ N Alcohol/Drug Abuse
- ☐ Y ☐ N Blood Clotting Problems
- ☐ Y ☐ N Blood Disease
- ☐ Y ☐ N Blood Thinners
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Bronchitis
- ☐ Y ☐ N Cancer / Tumor or Growth
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Chemical Dependency
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Chest Pain Upon Exertion
- ☐ Y ☐ N Color Blindness
- ☐ Y ☐ N Contact Lenses
- ☐ Y ☐ N Coumadin
- ☐ Y ☐ N Damaged Heart Valve
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Emphysema
- ☐ Y ☐ N Environmental Allergies
- ☐ Y ☐ N Epilepsy
- ☐ Y ☐ N Glaucoma
- ☐ Y ☐ N Hay Fever
- ☐ Y ☐ N Heart Attack
- ☐ Y ☐ N Heart Disease / Angina
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Heart Problems
- ☐ Y ☐ N Hepatitis / Jaundice
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Hives / Skin Rash
- ☐ Y ☐ N Joint Replacement
- ☐ Y ☐ N Kidney / Bladder Trouble
- ☐ Y ☐ N Leukemia
- ☐ Y ☐ N Liver Disease
- ☐ Y ☐ N Low Blood Pressure
- ☐ Y ☐ N Mental Health Problems
- ☐ Y ☐ N Mitral Valve Prolapse
- ☐ Y ☐ N Nervous Problems
- ☐ Y ☐ N Pacemaker
- ☐ Y ☐ N Persistent Diarrhea
- ☐ Y ☐ N Premedicate
- ☐ Y ☐ N Respiratory Disease
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Rheumatic Heart Disease
- ☐ Y ☐ N Seizures
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Stadol
- ☐ Y ☐ N Stomach Ulcers
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Tuberculosis
- ☐ Y ☐ N Unusual Weight Loss
- ☐ Y ☐ N Urinate Frequently
- ☐ Y ☐ N Other
- ☐ Y ☐ N See Medical Questionairre
- ☐ Y ☐ N See Dental Questionairre

☐ Y ☐ N Anemia
☐ Y ☐ N Ankles Swell
☐ Y ☐ N Anorexia / Bulimia
☐ Y ☐ N Arthritis
☐ Y ☐ N Asthma

☐ Y ☐ N Fainting Spells
☐ Y ☐ N Fever Blisters / Herpes
☐ Y ☐ N Frequent Headaches
☐ Y ☐ N Frequently Dry Mouth / Sjogren
☐ Y ☐ N Gall Bladder Trouble

☐ Y ☐ N Prior Hepatitis
☐ Y ☐ N Psychiatric Care
☐ Y ☐ N Radiation Treatment

Dental Questionaire

Dental Questionaire

Name of previous Dentist _____

Phone _____

Date of your last cleaning _____

Last exam date _____

Date of your last full series x-rays _____

Date of last cavity detection (bitewing) x-rays _____

Do your gums bleed while brushing or flossing ? ☐

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

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ? ☐

Have you ever had burning of the tongue or cracking of the corners of your mouth ? ☐

Do you chew/smoke tobacco in any form ? ☐

Have you had any head, neck or jaw injuries ? ☐

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ? ☐

Do you clench or grind your teeth ? ☐

Have you ever had orthodontic treatment ? ☐

If Yes, date of placement _____

Do you wear dentures or partials ? ☐

If Yes, date of placement of dentures ? _____

Are you happy with your dentures ? ☐

Are you having any specific problems with your teeth, gums, or mouth at this time ? ☐

Are you happy with your smile ? ☐

Do you have problems with teeth/fillings breaking ? ☐

Do you regularly use dental floss ? ☐

Do you have ever been told you have Pyorrhea ? ☐

Do you have difficulty in opening your mouth widely ? ☐

Do you have an unpleasant taste or odor in your teeth/mouth ? ☐

Does food catch between your teeth ? ☐

Do you want to learn to control your dental disease and retain your teeth ? ☐

Reviewed By

Additional Comments _____

Medical Questionnaire

Family Physician _____

Phone _____

Pharmacy Phone # _____

Are you currently under care of a Physician ? ☐

If Yes, what is the condition being treated ? _____

Have you had any serious illness, operation or been hospitalized within the past 5 years ? ☐

If Yes, what illness or problem ? _____

Are you currently taking any medication ? ☐

If Yes, what ? _____

Have you ever taken the diet control drug Fen-Phen ? ☐

Do you use alcoholic beverages ? ☐

Do you smoke ? ☐

Women Only

Are you pregnant? ☐

If Yes, what is your due date ? _____

Are you currently nursing ? ☐

Do you have menstrual period problems ? ☐

Are you on hormone replacement therapy ? ☐

Are you on birth control pills / fertility drugs ? ☐

Any Disease, Condition or Problem not Listed ? Please list _____

Additional Comments

Any Allergies not Listed? Please List: _____

Senior Citizen

Are you in a wheelchair? _____

Any condition not listed, please comment. _____

Have you been diagnosed with herpes?type? _____

By signing below, I certify that all of the above information is true to the best of my knowledge.

_____ _____

Patient/Guardian Signature **Date**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

*** You May Refuse To Sign This Acknowledgement ***

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMAITON ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMAITON.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually unidentifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information issued. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identify led health information by removing all references to individually identifiable information.

We may contact you to provide appointment renders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosers will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written requires to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communication of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.

_____, have received a copy of this office's Notice of Privacy Practices.

(Please Print Name)_____ (Signature)_____(Date) _____