PATIENT INFORMATION

Patient Name _____ Preferred Name _____

Date of Birth _____ Social Security _____-_____-_____ Sex ☐ M ☐ F Marital Status_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email_____ Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone Number _____

INSURANCE INFORMATION

Name of Dental Insurance Company _____ Policy Holder's Employer _____

Name of Policy Holder _____ Relation to Patient _____

Policy Holder's Date of Birth _____ Policy Holder's Social Security _____-_____-_____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Have you ever had the following? (Check boxes that apply)

☐ Allergies	☐ Epilepsy	☐ Pacemaker
☐ Arthritis	☐ Headaches	☐ Psychiatric Care
☐ Artificial Heart Valves, Joints, Screws, etc	☐ Heart Murmur	☐ Radiation Treatment
☐ Back Problems	☐ Heart Problems	☐ Recent Weight Loss
☐ Bleeding Abnormally	☐ Hemophilia	☐ Respiratory Disease
☐ Blood Disease	☐ Hepatitis, Jaundice or Liver Disease	☐ Rheumatic Fever
☐ Cancer	☐ Hernia Repair	☐ Sinus Problems
☐ Chemical Dependency	☐ High Blood Pressure	☐ Special Diet
☐ Chronic Diarrhea	☐ HIV/AIDS	☐ Stroke
☐ Circulatory Problems	☐ Low Blood Pressure	☐ Swollen Neck Glands
☐ Congenital Heart Lesions	☐ Mitral Valve Prolapse	☐ Ulcer
☐ Diabetes	☐ Nervous Problems	☐ Venereal Disease

Do you have any drug allergies or have ever had an adverse reaction to any medication or anesthesia? ☐ Yes ☐ No
If so, what? _____

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No
Are you taking any medications at this time? _____ If so, what? _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names phentermine), Pondimin, (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

If patient is a child, what is his/her weight? _____

Is there a chance you maybe pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Is there anything else we should know about your medical history?

_____

_____

CERTIFICATION

To the best of my knowledge, the information provided on this form is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

MINOR/CHILD CONSENT

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child
and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

INSURANCE ASSIGNMENT AND RELEASE

I certify that my dependent(s) is covered by insurance with _____
Name of Insurance Company(ies)
and assign directly to **Dr. Joseph Buono** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Joseph Buono may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

_____ _____
Signature of Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Parent, Guardian or Personal Representative Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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

_____
Please Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify)

_____

_____

_____

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 are required by applicable federal and state 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 must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect ___/___/___, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. 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 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and 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.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare 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 healthcare 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 an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your 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.

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 healthcare or with payment for your healthcare, 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 locating) 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 incapacity or 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.

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 are a possible 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 institution or law enforcement official having lawful custody or protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0. ____ for each page, $ ____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: 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. (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: 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.

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 us using the contact information listed at the end of this Notice. You may also 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.

Contact Officer: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

To My Valued Patient,

This year marks the beginning of many exciting changes in my office; we have invested in new technology and training in an effort to improve the service and the quality of care for you. We have invested in a DIAGNODENT, which is a laser caries detection aid. This instrument can detect decay much earlier then our eyes can. We have also introduced the VIZILITE PLUS cancer screening system. This system is the only medical device that the FDA has cleared for the identification of oral abnormalities in patients at increased risk for oral cancer.

My staff and I as a team have renewed our commitment to our patients. We have defined our Vision, Purpose and Values that we will live by. We will continually maintain and update our education, our office and equipment so that we can provide the best care and service in the community.

I have a personal, professional, and ethical responsibility to care for your health to the best of my ability. Some things happen through out the year that may not be intentional but do affect the care we provide. Missed appointments and failure to comply with recommended treatment schedules and/or procedures prevent me from achieving my goal of optimum health for you. If you cannot keep your appointments and adhere to my treatment recommendations, I will not be able to continue treating you in good conscience. Therefore, the following policies must be agreed upon:

1. No-shows are not acceptable. Failure to make an appointment not only compromises your health but inconveniences other patients who may have requested an office visit during your scheduled appointment. If you cannot make an appointment (except in the case of an emergency) you are expected to call within 24 hours of your appointment to reschedule. There is a $50.00 fee for all no-show appointments and this fee is not covered by insurance.
2. Timeliness is required. We will see you on time and get you out on time unless there is an emergency. We request that you be on time for your visits. If you are more than 10 minutes late, you may have to reschedule your appointment. We do not want to compromise your dental care or the next patient's dental care.
3. Cleanliness and infection control are of the utmost importance. We have the latest sterilization technology and disinfect each treatment room after every patient. This is another important reason we demand timeliness of you and ourselves.
4. If you miss an appointment you must make it up. It is critical to your health to do so to avoid setbacks in the care and maintenance of your teeth and gums.
5. Insurance: Treatment recommendations are based on your health not on your insurance or lack thereof. If you have insurance it is your responsibility to be aware of what your benefits are. Remember insurance companies are not concerned about your health or well being we are. If you wish we can submit for an estimate of benefits; however you are fully responsible for any treatment performed. Your benefits are a contract between you and your insurance company. We cannot be responsible for what your insurance will or will not cover.
6. We run a Zero Balance office. We expect payment in full prior to or at the time treatment is provided. We have several financial options available for all of our patients. Please speak to the receptionist if you have any questions.
7. Our policy is to make your experience in our office an exceptional one. When we succeed, we would appreciate you telling your family and friends about our office.
8. It is our company policy to ensure the complete satisfaction of all of our patients with the service and care they receive at our office. However, it is possible on occasion that there may be a misunderstanding or miscommunication between you and our office. We will do everything in our power to make things right by you, should a problem occur provided you bring it to our attention in an appropriate, cordial manner at a time that we can give the matter the proper attention it deserves for effective resolution. You can expect that my staff will treat you with the same professional demeanor and efficiency, as you would expect from them. Please see our office manager to resolve immediately any upsets you may have with my office or one of my team.
9. Emergencies. It is our goal to eliminate all of the potential dental emergencies you may have by providing care for you before it becomes a problem. In the rare instance that you do have an emergency we want you to be assured that we will take care of you. In order to do this we would like define what a true emergency is. Swelling, bleeding, pain that has kept you up at night or requires medication, or a restoration in a visible area that falls out are all considered emergencies. If you have any of these symptoms we ask that you call us right away. We will provide you with the next available emergency appointment. We do set aside time each day for emergencies.

I greatly appreciate your cooperation.

Yours in Good Health,
Dr. Joseph M. Buono

_____ _____

Patient Office

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY)

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number _____

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other _____
_____

_____ _____
Patient Signature Date

_____ _____
Print Name Date of Birth

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosures of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency

RECORD OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

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_____

_____