Geller Family Dental

gellerfamilydental@gmail.com

gellerfamilydental.com

850 Bronx River Road • Bronxville, NY 10708

(914)776-1122

Chart#: _____ FOR OFFICE USE ONLY

Patient Name: _____ Last _____ First ____ MI

_____ Preferred Name

Title: _____ Mr/Ms/Mrs/etc

Gender: ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____

SS#: ___-__-____

Prev. Visit: _____

Email Address: _____

Best time to call: _____

Phone: _____ Home _____ Mobile _____ Work _____ Ext

_____ Fax _____ Other

Address: _____ Address 1

_____ Address 2

_____ City _____ State _____ Zip Code

Pharmacy name, address and telephone #:

_____

_____

Emergency contact name and telephone #:

_____

_____

Name and telephone number of your Physician, Cardiologist or any specialist:

_____

_____

Have you been hospitalized in the past (5) year? If so, for what?

_____

_____

Check all that apply:

- ☐ Abnormal Bleeding
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artifical Joints
- ☐ Asthma
- ☐ Bisphosphonates
- ☐ Blood Transfusion
- ☐ Cancer - Chemotherapy
- ☐ Circulatory Problems
- ☐ Colitis
- ☐ Cosmetic Surgery
- ☐ Diabetic
- ☐ Difficulty swallowing
- ☐ Drug Addiction
- ☐ Epilepsy - Seizures
- ☐ Fainting spells / Dizziness
- ☐ Fever Blisters
- ☐ Gastric Bypass surgery
- ☐ Glaucoma
- ☐ Growth on Head or Neck
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High cholesterol
- ☐ HIV + /AIDS
- ☐ In Good Health
- ☐ Jaundice
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pace Maker
- ☐ Psychiatric Condition
- ☐ Radiation Therapy
- ☐ Respiratory Problems
- ☐ Rheumatic fever
- ☐ Scarlet Fever
- ☐ Sinus Problems
- ☐ Stents
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Weight Loss- Unexplained
- ☐ No Medications

Patient Name: _____ _____ ____
Last First MI

_____
Preferred Name

Please list any other medical conditions not listed above:

_____

_____

Do you take any blood thinners? (Coumadin, Warfarin, Plavix, Aspirin, Aggrenox, Xarelto, Eliquis etc.) ◯ Yes ◯ No

Please list all medications you are currently taking:

_____

_____

Do you have any Allergies? ◯ Yes ◯ No

If yes check all that apply:

☐ Aspirin	☐ Codeine	☐ Dental Anesthetics	☐ Erythromycin
☐ Foods	☐ Household Bleach	☐ Jewelry	☐ Latex
☐ Metals	☐ Iodine	☐ Penicillin/Amoxicillin	☐ Tetracycline
☐ Seasonal/Environmental Allergies	☐ Sulfa		

Have you ever had an allergic reaction to Dental Anesthesia (Novocaine)? ◯ Yes ◯ No

If yes, what type of reaction and to what medication?

_____

_____

Joint Replacement: Do you have any artificial joints (hip, knee, elbow, shoulder, etc)? ◯ Yes ◯ No

Do you have an artificial heart valve? ◯ Yes ◯ No

Date of replacement surgery: _____

Were there any complications during surgery? ◯ Yes ◯ No

Have you ever taken, are currently taking, or scheduled to begin taking bisphosphonates for osteoporosis, hypercalcemia, multiple myeloma, metastatic cancer, skeletal complication resulting from Paget's disease, or bone pain? This includes Boniva, Alendronate (Fosamax), risedronate (Actonel), Aredia, and Zometa. ◯ Yes ◯ No

Date bisphosphonate treatment began: _____

Do you smoke or use tobacco? ◯ Yes ◯ No

Are you Pregnant? if yes, enter due date: _____

To the best of my Knowledge the information I provided is accurate and complete:

Signature _____

Date

Please review and update your insurance information

Patient Name:

Last _____ First _____ MI _____

Preferred Name _____

Primary insurance:

Name of Insured:

Last _____

First _____ MI _____

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address:

Address 1 _____

Address 2 _____

City _____

State _____ Zip Code _____-_____

Insured's Employer Name:

_____

Employer Address:

Address 1 _____

Address 2 _____

City _____

State _____ Zip Code _____-_____

Patient's relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name:

_____

Insurance Address:

Address 1 _____

Address 2 _____

City _____

State _____ Zip Code _____-_____

Secondary insurance:

Name of Insured:

Last _____

First _____ MI _____

Insured's Birth Date:

ID #:

Group #:

Insured's Address:

Address 1

Address 2

City

State Zip Code

Insured's Employer Name:

Employer Address:

Address 1

Address 2

City

State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Address:

Address 1

Address 2

City

State Zip Code

Patient Name:

Last First MI

Preferred Name

Our office policy

If this office accepts your insurance as full payment, there will only be an out-of-pocket expense for non-covered services, or if your yearly maximum has been reached. This is your responsibility.

If you have insurance whereby you have a co-payment per visit, this co-payment is required at time of service, unless prior arrangements have been approved.

If you do not have dental insurance, payment is required at time of service.

We work by appointment only. A charge will be made for any appointment broken without any advanced notice or any repeated last minute cancellations.

Your insurance does not cover broken appointments.

Financial Arrangements

Due to the highly specialized treatment that dentists provide, most treatment plans are usually complex. As a result of the amount of time that we invest in your treatment, along with material and overhead costs, payment is expected in full at the time of service unless other arrangements have been made in writing. For your convenience, we accept all major credit cards.

If you have dental insurance, we will contact your insurance company for you and determine as close as is possible what your portion is to pay on the date of service. This information is an estimate only and we cannot guarantee its accuracy. After your insurance company pays their portio, we will inform you of what balance, if any, is outstanding for you to pay. This amount will be due upon notification. Please note that your insurance policy is a contract between you and your insurance carrier. If for any reason your insurance carrier does not pay within forty-five days, as allowed by law, the balance will become your responsibility. In the unfortunate circumstance that your account becomes more than 90 days overdue, your account will be charged an additional collection fee of $50.00.

Agreement

I understand the financial arrangements and agree with this payment schedule as a method of payment for my treatment. I understand that I am responsible for my total dental cost regardless of any insurance coverage.

Patient

Signature _____

Date _____

Authorization

I have reviewed the information on this questionaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropiate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responible for all charges whether or not paid by insurance.

Signature _____

Date _____

Response Date: _____

Notice Of Privacy Practices

Geller Family Dental

850 Bronx River Road
Bronxville, NY 10708
914-776-1122 (Office)
914-776-2410 (Fax)
Gellerfamilydental@gmail.com

Patient Name: _____ (Last) _____ (First) ____ (MI)

_____
Preferred Name

This notice describes how medical information about you may be used and disclosed. This also covers how you can get access to this information. Please review carefully.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of privacy pratices. This notice describes how we protect your health information and what rights you have regarding it.

◯ Yes ◯ No

[WE USUALLY WILL NOT] ask you for special written permission.

◯ Yes ◯ No

TREATMENT, PAYMENT AND HEALTH CARE OPERTAIONS
The most common reason why we use or disclose your health information for treatment, payment or health care operations. Examples of how we use

[We will ask for special written permission in the following situations: anything related to HIV/AIDS status, any sale information, any use of information for marketing or fundraising purposes, and _____.

-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; for the evaluation and health of members of the foreign service;

disclose information for 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; 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, asking you about your dental or medical care plan, or other sources of payment; preparing or sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those adminstrative and managerial functions for 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 rountinely use your health information inside our office for these purposes within any special permission. If we need to disclose your health information outside of our office for these reasons?

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In 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 mandate that certain health information be reported for specific purpose;

for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Adminstration regarding drugs or medical devices;

- disclosures to governmental authories about victims of suspected abuse, neglect or domestic violence;

-uses and disclosures for health oversight activites, such as or the license of doctors; for audits by Medicare or Medcaid, or for investigation of possible violations of health care laws;

-disclosures for judicial and adminstrative proceedings, such as in response to subpoenas or orders of court or admistrative agencies;

-disclosures for law enforcements purposes, such as to provide information about someone who is or is suspected to be victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;

-disclosure to 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 or disclosures for health related research;

-uses and disclosures to prevent a serious threat to health or safety;

-disclosures of de-identified information;

-discloures relating to worker's compenstaion programs; disclosures of ' limited data set' for research, public health, or health care operations;

Incidential disclosures that are an unavoidable by-product of permitted uses or disclosures;

disclosures to ' buisness associates' who perform health care operations for us and who commit to respect the privacy of your health information.

APPOINTMENTS REMINDERS

We may call or write to remind you of schedule appointments, or that it is time to make routine appointment. We may also call or write to notify you of other treatment of 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 on your home answering machine or with someone who answers your phone when you are not home.

OTHER USES AND DISCLOSURES

We will make any other uses or disclosures of you 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 autorization, 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 written. Send them to the office contact person named at the beginning of the 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 trestment (except emergency treatment), payment of healthcare operations. We do not have to agree to this, but if we agree, we must honor the restrictions that you want.We must honor restrictions not to send information to a health care plan regarding any service for which you have already made full payment. To ask for a restriction, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- ask us to communicate with you in confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E mail address. We will accomadate these request if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communcations, send a written request to the office contact person at the addres, fax or E mail shown at the beginning of this Notice.

- ask to see or to get photcopies 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 with in 10 days of asking us. You may have to pay for photcopies 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 our health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

☐ **- ask us to amend your health information if you think that is incorect 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 we 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 reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.**

- get a list 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 wil not include: disclosures for purposes of treatment, payment of health care opertalons; disclosures with yoy authorization; incidental disclosures; disclosures required by law; and some other limted disclosures. you are entitled to one such list per year without change. 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 recieving 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 request to the office contact person at the address, fax or E mail shown at the beginning of the Notice. Notified 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 terms of this Notice of Privacy Pratices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we can change this Notice, the new privacy pratices will apply to your health information that we already have well as to such information that we may generate in the future. If we change our Notice of Privacy Pratices, we will post new noitce in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of yor 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 a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If your 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.

Signature _____

Date

HIPAA Release form

Patient Name: _____ _____ ____
Last First MI

_____
Preferred Name

I authorize release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ spouse:

☐ Child(ren):

☐ Other:

☐ Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing

Signature _____
Date

Response Date: _____