Esthetix Dental Spa Medical History Form

Patient information

First Name: ____________ Last Name: ____________ Sex: ____

Address: ____________ Apt # ______ Marital Status: ________

City: ____________ State: ______ Zip Code __________

Birth Date: ____________ SSN: ________--________--________

Employer: ____________ Occupation: ____________

Home Phone: ____________

Work Phone: ____________

Cell Phone: ____________

Email: ____________@

____

Emergency Contact Information

Emergency contact name: ____________ Phone Number: ____________

Physician Name: ____________ Phone Number: ____________

Are any other members of your family patients of this office? YES / NO Name ____________

Who may we thank for referring you to our office? ____________

Responsible Party Information *If same as above, leave blank*

Name: ____________ Sex: ______

Address: ____________ Relationship to patient ________

City: ____________ State: ______ Zip Code ________

Birth Date: ____________ SSN: ________--________--________

Employer: ____________ Occupation: ____________

Home Phone: ____________

Work Phone: ____________

Cell Phone: ____________

Relationship to patient:

____

Dental Insurance Information

Dental Insurance Name: ____________

Group #: ____________

Phone Number: ____________

Subscriber information

Name: ____________

ID #: ____________ Birth Date: ____________

Employer: ____________

Relationship to patient: ____________

Consent for Services

I hereby authorize Estheticare Dental Consultants and staff to take and all necessary x-rays, study models, and photographs deemed necessary to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Estheticare Dental Consultants and/or staff to perform any recommended treatment mutually agreed upon. I agree to the use of anesthetics sedatives, and other medication as necessary. I fully understand that the use of medications and anesthetic agents embodies certain risks. I understand that I can request a full recital of any such risks or potential complications.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

____________ Date: ____________ Relationship to Patient: ____________

Signature of guarantor of payment/responsible party

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

Dental History

What is the reason for this appointment? ______________________________

Are there any specific dental problems we should know about? ______________________________

Are you aware of any decay or cavities?	YES NO	How often do you floss?	____________
Do you suffer from consistent bad breath or bad taste?	YES NO	How often do you brush?	____________
Do you have any jaw cracking or pain?	YES NO	Texture of your toothbrush?	____________
Do you clench or grind you teeth?	YES NO	When was your last cleaning?	____________
Have you had periodontal treatment?	YES NO	When were the last x-rays taken?	____________
Have you had orthodontic treatment?	YES NO	Name of your previous dentist?	____________
How would you describe your dental health?	EXCELLENT GOOD FAIR POOR		

Medical History *please circle yes or no*

ANY HEART PROBLEMS	YES	NO
HEART ATTACK	YES	NO
ANGINA	YES	NO
BYPASS	YES	NO
PACEMAKER	YES	NO
STROKE	YES	NO
HIGH BLOOD PRESSURE	YES	NO
LOW BLOOD PRESSURE	YES	NO
HEART MURMUR	YES	NO
MITRAL VALVE PROLAPSE	YES	NO
HEART VALVE DEFECT	YES	NO
HEART VALVE REPLACEMENT	YES	NO
RHEUMATIC FEVER	YES	NO
BLEEDING DISORDER	YES	NO
ANEMIA	YES	NO
HEMOPHILIA	YES	NO
SICKLE CELL TRAIT	YES	NO
BLOOD TRANSFUSION	YES	NO
ARTIFICIAL JOINT	YES	NO

DO YOU SMOKE?	YES	NO
LUNG/BREATHING PROBLEMS	YES	NO
ASTHMA	YES	NO
BRONCHITIS	YES	NO
EMPHYSEMA	YES	NO
TUBERCULOSIS	YES	NO
SINUS TROUBLE	YES	NO
DIABETES	YES	NO
DIFFICULTY HEALING	YES	NO
LIVER PROBLEMS	YES	NO
HEPATITIS/JAUNDICE	YES	NO
KIDNEY PROBLEMS	YES	NO
STOMACH TROUBLE/ULCERS	YES	NO
ALCOHOLISM	YES	NO
DRUG ABUSE	YES	NO
NERVOUS/MENTAL DISORDER	YES	NO
EPILEPSY/SEIZURES	YES	NO
THYROID PROBLEMS	YES	NO
ADRENAL/PITUITARY	YES	NO

ALLERGIC REACTION (HIVES/SWELLING):

PENICILLIN	YES	NO
ERYTHROMYCIN	YES	NO
SULFA	YES	NO
CODEINE	YES	NO
ASPIRIN	YES	NO
ANESTHETIC	YES	NO
LATEX	YES	NO
OTHER ____________		
INFECTIOUS DISEASES	YES	NO
HIV/AIDS	YES	NO
CANCER/TUMOR	YES	NO
GROWTHS	YES	NO
CHEMOTHERAPY	YES	NO
RADIATION	YES	NO
ARE YOU PREGNANT	YES	NO
HOW MANY MONTHS? ______		

Do you need to take antibiotic pre-medication prior to dental appointments?	YES	NO	Why?____________
Do you have any current health problems not listed above?	YES	NO	What?____________
Is a physician currently treating you?	YES	NO	Why?____________
Are you presently taking medications, pills, or tonics?	YES	NO	

Please list: ______________________________

Physician's name: ____________________ Phone Number: ____________

MEDICAL HISTORY REVIEWED: ____________________ Date: ____________

Notice of Privacv Practices

Initial____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMAION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable 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 is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", 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-identified health information by removing all references to individually identifiable information.

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

Any other uses and disclosures 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 request 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 personnel 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 to remove it.
- The right to reasonable requests to receive confidential communications 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.
- The right to obtain a paper copy of this notice from us upon request.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: __________ Relationship to Patient: ______________

Signature of patient, parent or guardian

Agreement

Initial____

7112I agree to be responsible for all charges for dental services and materials not paid by my dental plan, unless prohibited by law, or unless Estheticare Dental Consultants, has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to the use and disclosure of my protected health information (PHI) to carry out payment activities in connection with any and all claims.

Assignment of Benefits

Initial____

I hereby authorize and direct payment of dental benefits otherwise payable to me, directly to:

Estheticare Dental Consultants
285 Fort Washington Ave
New York, NY 10032
TIN: 200591101

Privacy Notice

Initial____

Estheticare Dental Consultants keeps a record of the dental care services that are provided to you. Our Notice of Privacy Practices describes in detail how your health information may be used and disclosed and how you can access that information. We will not disclose your record to others (except in the circumstances described in our Notice of Privacy Practices) unless you direct us to do so, unless the law authorizes us to do so, or unless circumstances compel us to do so. You may ask to see a copy of your record or get more information about it by contacting:

Estheticare Dental Consultants
285 Fort Washington Ave
New York, NY 10032

If you find information in your record to be incorrect, you may ask that the record be corrected by writing to the above address.

By my initialing above, I acknowledge that I have read, been given the opportunity to read, and/or have been provided a copy of Estheticare Dental Consultants Notice of Privacy Practices.

Financial Policy

Initial____

We cooperate fully with our patients who are covered by insurance plans. We expect insured patients to read their policies carefully. It is very important that you are familiar with its benefits and limitations. We will accept assignment of benefits provided the necessary documentation has been provided. We do require that you pay your deductible and/or estimated co-pay at the time of service. If your insurance company has not paid your account in full within 45 days of treatment or denies your claim for ANY reason, you are responsible for the total balance.

All estimates given for proposed treatment are not a guarantee of benefits. The office does not allow the insurance company to dictate recommended treatment. All prosthetic services must be paid in full on or before completion. We reserve the right to charge any account balance due over 30 days a 1.5% monthly finance charge or a $5.00 repeat billing charge, whichever is greater. You are responsible for any and all collection cost and/or fees associated with collecting the balance of your account. We consider the parent or guardian who brings the child to our office for treatment the responsible party for payment of the child's account. If someone else is legally responsible for the child's account, it remains the responsibility of the parent or guardian bringing the child in for treatment to seek reimbursement for payment made to our office. We will be happy to assist you by providing you with a copy of the charges and payments made at each visit. The office reserves the right to charge $50.00 **PER HALF HOUR** of a broken appointment up to the entire cost of treatment if not cancelled within the 48 hours. To avoid a charge, 48 hours notice must be given. Treatment plans signed and paid for must be cancelled within 48 hours for a refund minus 15% administrative fee. A $35.00 fee will be added to your account for any checks returned to us by the bank. A $25.00 fee will be assessed for the duplication of records/x-rays.