Welcome to our Practice!

My office and I are pleased that you chosen to come to us for your Dental Needs. We look forward to providing you with professional, courteous service, and excellent Dental Care. We always strive to make Dentistry a pleasant and positive experience. Your comfort and appearance are as much of a priority to us as they are to you.

Preventive dentistry is our goal for every patient. It involves the daily care, good nutrition and periodic check-ups and cleanings that maintain good dental health already achieved. Preventive dentistry may not be where we start with every patient, but is where we like to finish.

Restorative dentistry is basic repair of the mouth. We mend broken or leaking fillings, treat reoccurring decay, build onlays, crowns, and bridges, place implant restorations and realign the bite. Where necessary, gum disease is treated or root canal therapy recommended. The prevailing belief behind restorative dentistry is a simple one: you can keep all your teeth for all your life.

Cosmetic dentistry is coming of age with new materials and procedures that make a beautiful smile accessible to everyone. Because our preventive and restorative programs have been so successful, we now have the luxury of considering cosmetic treatment for gaps, chips, and otherwise less-than-perfect smiles. We expertly perform smile makeovers.

We provide any and all kinds of these services, depending upon your needs.

Good Doctor-Patient communication will give us the best opportunity to properly serve you. Please speak with us at the earliest opportunity if you have any questions or comments regarding our recommended treatment plan or alternative treatments that may be available.

Again, Welcome to our Practice.

Cary N. Goldstein, D.D.S.

PATIENT REGISTRATION

First Name: _____ Last Name: _____

Patient Is: (circle one) Policy Holder Responsible Party

Responsible Party (if someone other than the patient)
First Name: _____ Last Name:_____
Address: _____ Address2: _____
City, State, Zip:_____ Pager:_____
Home Phone: _____ Work:_____EXT:____ Cellular: _____
Birth Date: _____ Soc. Sec: _____ Drivers Lic:_____
Responsible Party Is: (circle one) Same as Patient Insurance Policy Holder

Patient Information:
Address:_____ Address2: _____
City: _____ State/Zip: _____
Home Phone:_____Work: _____EXT:_____ Cellular:_____
Sex (circle one) Female Male Martial Status: Married Divorced Single Widowed
Birth Date: _____ Age: ____ Soc. Sec:_____ Drivers Lic:_____
E-Mail_____ Referred By:_____

Section 2:
Employment Status:(circle one) Full Time Part Time Retired
Student Status: Full Time Part Time
Pref. Pharmacy & Phone: _____
Emergency Contact: _____ Emergency Contact #: _____
Relationship to Patient:_____

Primary Insurance Information:
Name of Insured: _____ Relationship to Patient: Self Spouse Child Other
Insured Soc. Sec:_____ Insured Birth Date: _____
Employer:_____ Insurance Company: _____
Insurance Company Address & Phone:_____
_____

Secondary Insurance Information:
Name of Insured: _____ Relationship to Patient: Self Spouse Child Other
Insured Soc. Sec: _____ Insured Birth Date:_____
Employer:_____ Insurance Company: _____
Insurance Company Address & Phone: _____

_____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around the 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.

Are you under a physician's care? (circle one) Yes No if yes, please explain_____
Have you ever been hospitalized or had a major operation? Yes No explain_____
Have you ever had a serious head or neck injury? Yes No if yes, please explain_____
Are taking Medications, pills, or drugs? Yes No if yeas, please explain _____
Do you use tobacco? Yes No If yes: How long? _____ How many a day? _____
Do you controlled substances? Yes No if yes, please explain _____

Women: Are You; pregnant or trying to get pregnant? ____ Taking contraceptives? _____Nursing? _____

Are you allergic to any of the following?: (circle those that apply)
Aspirin Penicillin Codeine Acrylic Metal Latex Local Atheistics
Other:_____

Do you have, or have you had, any of the following?
Mitral Valve Prolapse Heart Pace Maker Artificial Joint Irregular Heartbeat

Have you ever undergone? :
Chemotherapy or Radiation Treatments
Do you have, or have you had, any of the following? (circle those that apply)

o AIDS/HIV Positive	o Epilepsy or Seizures	o Sickle cell Disease
o Alzheimer's Disease	o Excessive Bleeding	o Sinus Trouble
o Anaphylaxis	o Excessive Thirst	o Spina Bifida
o Anemia	o Fainting Spells/Dizziness	o Stomach/Intestinal Disease
o Angina	o Frequent Cough	o Stroke
o Arthritis/Gout	o Frequent Diarrhea	o Swelling of Limbs
o Artificial Heart Valve	o Frequent Headaches	o Thyroid Disease
o Asthma	o Glaucoma	o Tonsillitis
o Blood Disease	o Kidney Problems	o Tuberculosis
o Blood Transfusion	o Leukemia	o Tumors or Growths
o Breathing Problems	o Liver Disease	o Ulcers
o Bruise Easily	o Low Blood Pressure	o Venereal Disease
o Chest Pains	o Lung Disease	o Yellow Jaundice
o Cold Sores/Fever Blisters	o Pain in Jaw Joints	o Hay Fever
o Congential Heart Disorder	o Parathyroid Disease	o Heart Murmur
o Convulsions	o Psychiatric Care	o Heart Attack/Failure
o Cortisone Medicine	o Renal Dialysis	o Hemophilia
o Diabetes	o Rheumatic Fever	o Herpes
o Drug Addiction	o Scarlet Fever	o High Blood Pressure
o Easily Winded	o Shingles	o Hypoglycemia
o Emphysema	o Hives or Rash	o Rheumatism

Have you ever had any serious illness not listed above? Yes No If Yes, please explain:_____
_____
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.

Patient Signature: _____

Patients without Insurance

For our Patients without insurance, we ask that you pay for services at the time they are provided. For your convenience, we accept Cash, Check, MasterCard, Visa, Discover, and American Express. Deferred Interest Payment Plans of 6-12 months are available through Care Credit and Unicorn Patient Financing, for those who qualify. Deferred Interest Payment Plans 18 months will incur a $75.00 processing fee.

PLEASE READ CAREFULLY

I, the patient, understand that I am responsible for any charges incurred by Cary Goldstein, DDS, Inc.

I, the patient, authorize Cary Goldstein, DDS/staff to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Dr. Goldstein to make a thorough diagnosis of the patient's dental needs. I also authorize Cary Goldstein, DDS/and staff to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk.

Effective immediately, patients must notify our office 48 hours in advance of their appointment to cancel or reschedule appointments. If appointments are not cancelled within 48 hours, I understand that my account will be charged a $35.00 **"NO SHOW"** fee.

_____ _____

Signature of Patient Date

_____ _____

Signature of Responsible Party Date

NOTICE OF PRIACY PRACTICES
(DENTAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
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 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. "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-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 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 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.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of, April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: (877)- 696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability Act of 1996 ("HIPPA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature: _____

Date: _____