



Patient Information

How did you hear about us?

Please circle one:

Referral - Who may we thank for referring you?

- Phonebook Newspaper*
- Flyer Letter*
- Brochure Other _____*

Internet: - Circle site name.

- garyrosenfelddds.com*
- eastislipdentist.com*
- eastislipdentalcare.com*
- superpages.com*
- yellowpages.com*
- yellowbook.com*
- locateadoc.com*
- dentists.com*

Please tell us about yourself:

Name _____

Address _____

Phone _____

Cell Phone _____

Check One: _____ Married _____ Unmarried

_____ Separated _____ Widowed

Sex: _____ Male _____ Female

Date of Birth _____

Social Security No. _____

Driver's License No. _____

E-mail Address _____

Current Employment _____

Address _____

Phone _____

Spouse, Parent or Guardian:

Name _____

Address _____

Phone _____

Cell Phone _____

Date of Birth _____

Social Security No. _____

Driver's License No. _____

Emergency Contact _____

Day Phone _____ Evening Phone _____

Name: _____ Date: _____

(Please print)

HEALTH HISTORY

Circle yes or no regarding any of the following past or present medical conditions. All information provided is confidential.

		<i>If yes, list all medications</i>			<i>If yes, list all medications</i>
Heart Failure	<i>Yes/No</i>		Sinus Trouble	<i>Yes/No</i>	
Heart Disease or Attack	<i>Yes/No</i>		Allergies or Hives	<i>Yes/No</i>	
Angina Pectoris	<i>Yes/No</i>		Diabetes	<i>Yes/No</i>	
High Blood Pressure	<i>Yes/No</i>		Radiation Therapy	<i>Yes/No</i>	
Heart Murmur	<i>Yes/No</i>		Cancer	<i>Yes/No</i>	
Mitral Valve Prolapse (MVP)	<i>Yes/No</i>		Chemotherapy (cancer, Leukemia)	<i>Yes/No</i>	
Congenital Heart Lesions	<i>Yes/No</i>		Arthritis	<i>Yes/No</i>	
Heart Pacemaker	<i>Yes/No</i>		Rheumatism	<i>Yes/No</i>	
Heart Surgery	<i>Yes/No</i>		Cortisone Medicine	<i>Yes/No</i>	
Rheumatic Fever	<i>Yes/No</i>		Glaucoma	<i>Yes/No</i>	
Stroke	<i>Yes/No</i>		Pain in Jaw Joints	<i>Yes/No</i>	
Any Type of Transplant	<i>Yes/No</i>		Blood Transfusion	<i>Yes/No</i>	
Any type of Implant (Heart valve, etc.)	<i>Yes/No</i>		Sexually Transmitted Diseases	<i>Yes/No</i>	
Artificial Hip, Knee, or other Joints (Pins or Rods used to repair broken bones)	<i>Yes/No</i>		HIV Positive, ARC, AIDS	<i>Yes/No</i>	
Alcoholism	<i>Yes/No</i>		Hepatitis A (infectious)	<i>Yes/No</i>	
Use Of Tobacco Products	<i>Yes/No</i>		Hepatitis B (Serum)	<i>Yes/No</i>	
Pregnant or Nursing	<i>Yes/No</i>		Hepatitis C	<i>Yes/No</i>	
Thyroid Disease	<i>Yes/No</i>		Jaundice	<i>Yes/No</i>	
Anemia	<i>Yes/No</i>		Liver Disease	<i>Yes/No</i>	
Kidney Trouble	<i>Yes/No</i>		Drug Addiction	<i>Yes/No</i>	
Ulcers	<i>Yes/No</i>		Hemophilia	<i>Yes/No</i>	
Birth Defects	<i>Yes/No</i>		Cold Sores	<i>Yes/No</i>	
Mental Retardation	<i>Yes/No</i>		Herpes	<i>Yes/No</i>	
Emphysema	<i>Yes/No</i>		Epilepsy or Seizures	<i>Yes/No</i>	
Cough	<i>Yes/No</i>		Fainting or Dizzy Spells	<i>Yes/No</i>	
Tuberculosis (TB)	<i>Yes/No</i>		Psychiatric Treatment	<i>Yes/No</i>	
Asthma	<i>Yes/No</i>		Sickle Cell Disease	<i>Yes/No</i>	
Hay Fever	<i>Yes/No</i>		Bruise Easily	<i>Yes/No</i>	

*****Antibiotic pre-medication may be required prior to your appointment *****

List all other medications being taken: _____

List all other conditions not mentioned above: _____

Have you been hospitalized in the past 2 years? __ Yes __ No _____

Have you been under the care of a physician in the past 2 years? __ Yes __ No _____

List all drugs that you are allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, clindamycin, tetracycline, erythromycin, sulfur, aspirin, codeine or any other drugs _____

Have you had any excessive bleeding requiring special treatment? __ Yes __ No _____

Are there any sores or growths in or around your mouth? __ Yes __ No _____

SIGNATURE: _____ **DATE:** _____



Insurance Information

	<u>1st Insurance Co.</u>	<u>2nd Insurance Co.</u>
Employee's Name	_____	_____
Social Security No.	_____	_____
Sex	_____	_____
Date of Birth	_____	_____
Insurance Co. Name	_____	_____
Insurance Co. Address	_____	_____
Insurance Co. Phone	_____	_____
Group Plan Number	_____	_____
Local Union Number	_____	_____
Policy Number (or BIC #)	_____	_____
Employer's Name	_____	_____
Employer's Address	_____	_____
	_____	_____
Family Members Covered	_____	_____
	_____	_____

DR. ROSENFELD AND HIS STAFF WILL ASSIST YOU IN EVERY WAY POSSIBLE WITH YOUR INSURANCE CARRIER; HOWEVER, IT IS NOT ALWAYS POSSIBLE TO PREDICT WHICH SERVICES ARE COVERED BY THE CARRIER OR HOW MUCH THEY WILL PAY FOR A PARTICULAR SERVICE. PLEASE CONTACT YOUR INSURANCE CARRIER WITH ANY QUESTIONS REGARDING YOUR COVERAGE. PATIENTS WITH INSURANCE ARE RESPONSIBLE FOR PAYMENT OF THEIR BILLS.

Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer, Mrs. Kellie Rosenfeld.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Date _____

Print Name _____

Signature _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.