Welcome!

We would like to welcome you to our office. Our goal is to make everyone's visit pleasant and educational. We strive to teach exceptional oral care that will enable you to have a beautiful smile that lasts a lifetime.

1 Patient Information

Today's Date _____

First Name _____ MI _____

Last Name _____

Birthdate _____ Age _____ SS# _____

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Address _____

_____

Home # _____ Cell # _____

Employer _____ Work # _____

Occupation _____

Email _____

Referred by _____

Emergency Contact Name: _____

Emergency Contract Phone # _____

2 Responsible Party

First Name _____ MI _____

Last Name _____

Birthdate _____ Age _____ SS# _____

Employer _____ Work # _____

Occupation _____

Employer's Address _____

_____

3 Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Plan _____ Group _____ Policy _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate _____ SS# _____

Policy Owner's Employer _____

Employee's Address _____

_____

Orthodontic Coverage? ☐ Yes ☐ No

4 Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Plan _____ Group _____ Policy _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate _____ SS# _____

Policy Owner's Employee _____

Employee's Address _____

_____

Orthodontic Coverage? ☐ Yes ☐ No

5 Dental History

Purpose of today's visit _____

Previous Dentist _____

Date of last visit _____

What was done _____

Last Cleaning _____

How often do you brush _____ Gums bleed ☐ Yes ☐ No

Any ☐ Sensitive teeth ☐ Loose teeth ☐ Broken fillings

☐ Jaw pain ☐ Injuries to teeth

Explain _____

Unpleasant Dental Experience ☐ Yes ☐ No

Explain _____

Have you ever had ☐ Orthodontics ☐ Gum Treatment ☐ Implants

☐ Root Canal ☐ Oral Surgery ☐ Crowns ☐ Veneers

Are you happy with the appearance of your teeth?

☐ Yes ☐ No ☐ Color ☐ Position ☐ Smile

Have you ever had tooth whitening? ☐ Yes ☐ No

☐ In Office ☐ Overnight ☐ Drug Store

Are you interested in replacing any missing teeth? ☐ Yes ☐ No

Which method ☐ With Dentures ☐ Bridges ☐ Implants

Do you have any questions for the doctor? ☐ Yes ☐ No

I authorize the doctor to perform all recommended treatment agreed upon by me and to use the appropriate medication and therapy for such treatment in connection with _____. I understand that using anesthetic agents embodies a certain
(NAME OF PATIENT)
risk. Furthermore, I authorize and give consent to the doctor to use and employ such assistant as deemed to provide recommended treatment.

6 Medical History

Physicians Name _____

Office Address _____

_____

Telephone _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Explain _____

Has there been a recent change in your health? ☐ Yes ☐ No

Explain _____

Are you currently taking any prescription, over the counter or recreational drugs? ☐ Yes ☐ No

Explain _____

_____

_____

_____

Have you been hospitalized or had a serious illness within the past five years? ☐ Yes ☐ No

Explain _____

Have you been treated now or in past with Bisphosphonates for Osteoporosis or cancer? ☐ Yes ☐ No

Explain _____

Are you Pregnant or is it likely that you could be pregnant at this time? ☐ Yes ☐ No

Explain _____

Do you?

☐ Smoke Packs per day?_____ How long?_____
☐ Chew Tobacco
☐ Drink Per week? _____Per Month?_____
☐ Wear Contact Lenses
☐ Take Diet Pills
☐ Take Herbal Supplements

Circle if you have or ever had

Y	N	Artificial Limb/joint/hip	Y	N	Chronic Diarrhea
Y	N	High/low Blood Pressure	Y	N	Stoke TIA
Y	N	Organ Transplant	Y	N	Joint Surgery
Y	N	Sinus Problems	Y	N	Cancer/Chemotherapy
Y	N	Migraines	Y	N	Blood Disorder
Y	N	Frequent Headaches	Y	N	Increased Frequent
Y	N	Claustrophobia			Urination
Y	N	Artificial Heart Valve	Y	N	Bells Palsy
Y	N	Prolonged Bleeding	Y	N	Heart Disease
Y	N	Ulcers/colitis	Y	N	Diabetes
Y	N	Hay Fever	Y	N	Asthma
Y	N	Head injury	Y	N	Night Sweat
Y	N	Venereal Disease	Y	N	Psychiatric/Emotional
Y	N	Mitral Valve Prolapse	Y	N	Recurrent Infections
Y	N	Acid Reflux	Y	N	Angina
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Epilepsy/seizures	Y	N	Bronchitis
Y	N	STD	Y	N	Addictions
Y	N	Rheumatic Fever	Y	N	Pace Maker
Y	N	Radiation Therapy	Y	N	Liver Problems
Y	N	Stomach Problems	Y	N	Emphysema
Y	N	Glaucoma	Y	N	TMJ Problems
Y	N	Dizziness/Fainting spells	Y	N	Shortness of Breath
Y	N	Treated for AIDS,HIV, ARC	Y	N	Hepatitis: A or B or C
Y	N	Heart Murmur	Y	N	Tuberculosis
Y	N	Thyroid Problems	Y	N	Unexplained Weight Loss
Y	N	Used Diet Drug Fen-Phen	Y	N	Mouth Ulcers
Y	N	Anemia	Y	N	Aspirin Daily

Please mark any allergies/adverse reactions :

Y	N	Penicillin	Y	N	Aspirin
Y	N	Tetracycline	Y	N	Valium
Y	N	Erythromycin	Y	N	Barbiturates
Y	N	Sulfa	Y	N	Latex
Y	N	Local Anesthetics	Y	N	Iodine
Y	N	Codeine	Y	N	Household
Y	N	NSAID (Advil/Motrin)			Bleach
Y	N	Gluten	Other _____		

_____ _____
Patient or Responsible Party Signature Date

_____ _____
Dentist Signature Date

Patient Consent to Receive Mail, E-mail, and/or Telephone Messages

Please Print (Last Name) (First Name) (M.I.)

I agree that the practice may communicate with me electronically at the following address:

Phone Number E-mail Address *(please print)*

I consent to receive calls and text messages related to my protected healthcare and other services at the phone number(s) above, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Do we have your permission to:

Send a recall appointment reminder to your home? Y____ N____

Leave appointment, billing or dental information on your answering machine/voice mail/e-mail: Y____ N____

I give permission to share appointment, billing or dental information with the person named below:

Name: _____

_____ _____
Signature of Patient/Parent or Legal Guardian Date

If signed by other than patient, specify relationship to patient: _____

Acknowledgment of Receipt of Notice of Privacy Practices

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

_____ _____
Signature of Patient / Parent or Legal Guardian Date

If signed by other than patient, specify relationship to patient: _____

FOR OFFICE USE ONLY

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

- ☐ Patient / Parent or Legal Guardian refused to sign form
- ☐ Other

_____
Signature of Office Manager Date

Konikoff Dental Associates – Little Neck

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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on the above date, 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 provide the new Notice at our practice location, and we will distribute it 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 without authorization for the purposes of treatment, payment, and healthcare operations.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a doctor 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. For example, 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 the following purposes, 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.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of 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 absence or incapacity or in 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.

Marketing or Sale: We will not use your health information for marketing communications, nor disclose your health information in exchange for remuneration, without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

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 the protected health information of an inmate or patient under certain circumstances.

Correspondence: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters), correspondence, and missed appointment notification.

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. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. 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 and Breach Notification: 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. Affected patients have a right to be notified following a breach of unsecured protected health information.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact our Privacy Official, David Quigley, Esq., 6240 Lake Osprey Drive, Sarasota, FL 34240, Ph. #: (941) 955-3150.

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 also may 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.