**Patient Consent form (HIPAA)**

Our notice of privacy Practices provides information about how we may use and disclose Protected Health Information, (PHI), about you. The notice contains a Patients Right section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected the PHI about you is used or disclosed for treatment, payment and health care operation. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our policy of PHI. You have the right to revoke This consent signed, in writing, signed by you. However, such revocation shall not Affect any disclosures we have made in reliance on your prior consent. We have provided this form to comply with the Health Insurance Portability and Accountability Act of 1996(HIPAA).

The patient understands that:

- Protected Health Information may be disclosed or used for treatment, payment or health care operation.
- The practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the use of his/her information but the Practice doesn't have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The practice may condition treatment upon the execution of this consent.

________________________________________
Patient or Guardian Name (Printed)

________________________________________ _______________

Patient or Guardian Name (Signed) Date

# Office and Payment Policies Form

Page 1

**Important: Do not sign this form without reading and understanding its content. Please check each section to indicate you have read and understand it.**

- [ ] Insurance - If you are not covered by any dental insurance plan or this practice is not a participating provider with your dental plan, full payment of all office visits and other service charges is expected at the time services are provided. *

Charges for all services are the responsibility of the patient, whether or not covered by insurance. We will file insurance claims for patients if we have a current copy of the patient's insurance card on file. However, all patient payments, noncovered service charges, and deductibles as required by your insurance are due at the time of service.

Each insurance plan has a different set of procedures that are eligible for payment, and may have limits on the number and timing of visits, x-rays, and procedures. We may not know at the time of your visit if your insurance company will pay for all services and you may not be notified that a service is not covered at the time of your visit. If your insurance company does not pay for these services, you accept responsibility for full payment of these charges. Charges for certain procedures must be paid for by you prior to having the service provided.

Regulations mandate that insurance companies pay for undisputed claims within 30 days of submission. We will allow 45 days for your insurance to pay a claim. If your insurance company has not paid in full by this time, you will be responsible for all outstanding charges. Please follow up with your insurance company to make sure they pay your claims. We will refund any overpaid amount to the patient or insurance company as appropriate.

We rely on the insurance information you give us in filing insurance claims for you. If we do not have correct insurance information at the time of service we may not be able to file your claim before the "timely filing" period ends. If the insurance information that you provide us is not accurate, you will be liable for the full amount of all charges and agree to pay these charges in full.

- [ ] Payment -We accept cash, credit cards, checks and we participate with Care Credit patient financing. *

- [ ] Account Credits - If you or one of your family members has a credit on their account, you authorize us to use that credit at any time toward payment of any amounts owed on either account. Credits of $20 or less may be left on account without notification. *

- [ ] Delinquent Accounts - Once we have exhausted our internal efforts to obtain payment for service, we will refer accounts to an outside collection agency. These agencies report delinquent accounts to credit reporting services. You will be charged and agree to pay a $50 fee and for all collection and/or attorneys' fees that we may incur trying to collect on your account. *

- [ ] Returned checks - Occasionally, a check written to us is returned unpaid. Returned checks must be paid in full within 10 days of notification plus a $40 fee and must be paid in cash or with a money order or cashier's check. *

- [ ] Medical records fee - I understand that federal and state laws allow for a fee to be charged for copying of patient records and I will be personally responsible for the payment of such fees. One copy of up to 75 pages of patient records will be provided at no cost. Any records over 75 pages and any records after the first copy will be billed at the current rates payable prior to records being released. *

- [ ] Scheduling - Patient who do not show up for an appointment, arrive too late, or cancel with less than 48 hours’ notice, may be billed and agree to be responsible for full payment of a $50.00 charge. Broken appointment for surgery or major procedures will result in a $100.00 charge due to the amount of time scheduled and advance planning required. *

- [ ] Safety - For safety and liability reasons, only the patient may be in the treatment room during treatment. Allowing a child in the room while the parent is being treated puts the child at risk for injury from sharp instruments, chemicals, and/or bacteria aerosols present in the room. Children are welcome to wait in the reception room but we are not responsible for the safety or supervision of children in the reception room. *

- [ ] Prescriptions - Please allow 24 hours for processing the refill of any prescription. Current law does not allow narcotics to be prescribed by phone, a written prescription is required. Narcotics will not be prescribed after hours or on the weekends, and lost or stolen prescriptions will not be replaced. *

I have read, understand and agree to the Office and Payment Policies as stated above. This consent will remain valid indefinitely unless revoked in writing.

Patients First Name *

Patients Last Name *

☐ I am signing on behalf of the patient

Signature *

Today's Date

10/18/2023

# Adult Patient Information

Page 1

## Patient's Information

Last Name *

First Name *

MI

_

Date of Birth *

MM/dd/yyyy

Age

0

Soc. Sec. #

___-__-____

Today's Date *

10/18/2023

Gender *

○ Male ○ Female ○ Non-binary/ Other

Marital Status

○ Single ○ Married ○ Child ○ Other

Preferred Pharmacy and Address *

Preferred Pharmacy and Address

☐ I am filling this form out for the Patient

Page 2

## Patient's Contact Information

Patient's Cell Phone Number *

(___) ___-____

Patient's Email *

Patient's Home Phone Number

(___) ___-____

Patient's Driver's License #

Mailing Address *

City *

State *

Please select

Zip Code *

_____

Page 3

## Emergency Contact Information

Full Name

Phone Number

(___) ___-____

Relationship

Page 4

## How did you hear about us?

- [ ] Google
- [ ] Neighborhood
- [ ] Insurance
- [ ] Practice Website
- [ ] ZocDoc
- [ ] Family/Friend/Referred
- [ ] Other

Page 5

To the best of my knowledge, all the information I have provided is true.

First Name *

Last Name *

Patient's Signature *

Today's Date *

10/18/2023

Brooklyn CITY DENTAL

Name ______ Gender Female ______ Age ______ Date of Appointment: ______

## Reason for Visit

What brings you to the office today?

How is your oral hygiene?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns you would like to address?

## Current Medications

What medications are you currently taking?

Name ______ Dosage ______ Frequency ______

Name ______ Dosage ______ Frequency ______

Name ______ Dosage ______ Frequency ______

Name ______ Dosage ______ Frequency ______

## Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name ______ Reaction ______

Name ______ Reaction ______

## Past Medical History

☐ Alcoholism ☐ Allergies ☐ Anemia ☐ Anxiety Disorder ☐ Arthritis ☐ Asthma ☐ AIDS / HIV
☐ Back Problems ☐ Bleeding Disorder ☐ Blood Disease ☐ Blood Transfusion ☐ Cancer ☐ Diabetes ☐ Depression
☐ Ear Problems ☐ Eating Disorder ☐ Epilepsy ☐ Glaucoma ☐ Gout ☐ Heart Disease ☐ Heart Problems
☐ Hepatitis - A, B, or C ☐ High Blood Pressure ☐ High Cholesterol ☐ Joint Disorder ☐ Kidney Disorder ☐ Liver Disorder ☐ Lung Disease
☐ Measles ☐ Migraines ☐ Osteoporosis ☐ Pneumonia ☐ Polio ☐ Rheumatic Fever ☐ Stroke
☐ Skin Disorder ☐ Stomach Ulcer ☐ Substance Abuse ☐ Thyroid Disorder ☐ Tuberculosis ☐ Venereal Disease

## Hospitalizations & Surgeries

Reason ______ Date ______

Reason ______ Date ______

## Women Only:

# of Pregnancies ______ # of Miscarraiges ______ # of Abortions ______ # of Living ______

Last Pap Smear ______ Last Mammogram ______ Birth Control Method ______

## Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism ☐ Allergies ☐ Alzheimer's ☐ Anemia ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ AIDS/HIV ☐ Bleeding Disorder ☐ Blood Disorder
☐ Cancer ☐ Depression ☐ Diabetes ☐ Epilepsy ☐ Genetic Disorder ☐ Glaucoma ☐ Heart Disease ☐ Hepatitis ☐ High Cholesterol ☐ High Blood Pressure
☐ Joint Disorder ☐ Kidney Disease ☐ Liver Disorder ☐ Lung Disease ☐ Migraines ☐ Psychiatric Disorders ☐ Osteoporosis ☐ Stroke ☐ Substance Abuse ☐ Thyroid Disorder

## Communications Consent:

_____ (Patient initials) I consent to receiving appointment reminders and other healthcare communications/information at that email and/or text from Brooklyn City Dental, to the numbers provided on this intake form.

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders, feedback, health information unless

I request a change in writing.