MICHAEL MANASAR DENTISTRY

PATIENT REGISTRATION

TODAY'S DATE_____

Patient's Name	**Birth date**		**Age**	**Sex:** **M F**
Home Address	**City**	**State**	**Zip**	
Home Phone #	***Please Circle One:*** Single, Married, Separated, Widow		**Your Social Security Number**	
Your Employer	**Occupation**		**Work Phone #**	
Person responsible for account:			**YOUR Driver's License Number:**	
Name of spouse (or parent if minor)			**YOUR E-mail address**	**YOUR cell phone #**
Spouse's (or parent's) employer	**Spouse's Soc. Sec. #**		**Work phone #**	

EMERGENCY INFORMATION

Name, Address, & Telephone of A relative not living with you:

How did you hear about our office?

Reason for this visit?

DENTAL INSURANCE INFORMATION (Primary Carrier)			**If you have a dual insurance coverage, complete this for the second coverage (this office bills primary ins only)**		
Insured's name	**DOB**	**SS#**	Insured's name	DOB	SS#
Insured's employer			Insured's employer		
Insurance Co			Insurance Co		
Insurance Co Address			Insurance Co Address		
Phone #			Phone #		
Group #	**Policy #**		Group #		Local #

Is there anything other than your medical or dental history that we should know?

Patient Signature (or parent of child)	Date	Doctor's Signature

MICHAEL MANASAR DENTISTRY

DENTAL HISTORY

Please mark Y or N note if you currently have any of the below symptoms:

- **Y N** Sensitivity (hot, cold, sweet)
- **Y N** Tooth pain or discomfort when chewing
- **Y N** Headaches, ear aches, neck pain
- **Y N** Mouth ulcers or cold sores
- **Y N** Jaw joint pain
- **Y N** Broken tooth or fillings
- **Y N** Grinding or clenching teeth
- **Y N** Bleeding, swollen or irritated gums
- **Y N** Loose, tipped or shifted teeth
- **Y N** Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

- **Y N** Dentures
- **Y N** Partial dentures
- **Y N** Braces
- **Y N** Gum treatments
- **Y N Required to take antibiotics prior to dental treatment**

Please share the following dates:

Your last cleaning _____/_____
Your last oral cancer screening _____/_____
Your last complete x-rays _____/_____

Name of Previous Dentist:
Name: _____
Street: _____
City: _____ State: _____
Phone number: _____

If you could whiten your teeth for a cost anyone could afford, would you do it?

_____

Do you smoke or use chewing tobacco?
How much? For how long?

_____

If you could change your smile, you would:

- **Y N** Make my teeth whiter
- **Y N** Make my teeth straighter
- **Y N** Close spaces
- **Y N** Replace metal fillings with tooth colored fillings
- **Y N** Repair chipped teeth
- **Y N** Replace missing teeth
- **Y N** Replace old crowns that don't match
- **Y N** Have a smile makeover

On a scale of 1 -10, with 10 being the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your dental visit today?

_____
_____
_____
_____

Why did you leave your previous dentist?

_____
_____
_____
_____

MICHAEL MANASAR DENTISTRY

MEDICAL HISTORY

Please check any of the following that apply to you:

Y N Allergies (Seasonal)
Y N Anemia
Y N Artificial Heart Valve
Y N Artificial Joints
Y N Asthma
Y N Blood Disease
Y N Bruise Easily
Y N Cancer
Y N Chemotherapy
Y N Diabetes I or II
Y N Dizziness/Fainting
Y N Drug Addiction
Y N Emphysema
Y N Excessive Bleeding
Y N Glaucoma
Y N Heart Conditions
Y N Heart Murmur
Y N Hepatitis A
Y N Hepatitis B
Y N Hepatitis C
Y N High Blood Pressure
Y N HIV/AIDS
Y N Jaundice
Y N Kidney Disease
Y N Liver Disease
Y N Mitral Valve Prolapse
Y N Nervousness/Depression
Y N Pacemaker
Y N Phen Fen (1 month +)
Y N Radiation (head/neck)
Y N Respiratory Problems
Y N Rheumatic Fever
Y N Rheumatism
Y N Scarlet Fever
Y N Seizures
Y N Stomach Problems
Y N Stroke
Y N Thyroid Disease
Y N Tuberculosis
Y N Ulcers
Y N Have you ever taken Bisphosphonates? (i.e. Aredia, Fosamax,Boniva)
Y N Vit. D Deficiency
Y N Other:

_____

_____

For WOMEN Only

❑ Birth Control Pills
❑ Breast-feeding
❑ Pregnant

1-3 mos,3-6 mos,6-9mos,

Do you have an allergy to any of the following?

Y N Aspirin
Y N Codeine
Y N Erythromycin
Y N Latex
Y N Local Anesthetic
Y N Nitrous Oxide
Y N Penicillin

Please list any other allergies here:

_____
_____
_____
_____

What Medications are you currently taking?

_____
_____
_____
_____
_____
_____
_____

Are you under a physician's care? For what?

_____
_____
_____

Name of Physician:

_____

Physician Phone Number:

_____

Patient Signature (or parent of child)	Date	Doctor's Signature

HIPAA Notice of Privacy Practices

Michael E Manasar, DDS
83 E Main Street
Wappingers Falls, NY 12590
845-297-6432

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.
Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. **You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **September 30, 2014.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____ Date_____

MICHAEL MANASAR DENTISTRY

FINANCIAL Guidelines

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, American Express, and Discover. Outside financing is available upon request and approval.

Please check if you would like more information about financing options. ☐

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred.

- As a courtesy to you we will help you process all your insurance claims.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you pay for your treatment in full at the time of service by cash, check, MasterCard, Visa, American Express, or Discover.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

_____ _____

PATIENT Signature (Parent of Child) *Date*