110 CrossKeys Office Park
Fairport, NY 14450
585-223-8690
CrossKeysDental@Frontier.com
www.crosskeysdentalfairport.com

PATIENT INFORMATION

(Confidential)

Birthdate: _____

Soc. Sec. #: _____

Today's Date: _____

Patient's Name: _____ Phone #: _____

Address: _____ City: _____ State: ____ Zip: _____

Please Circle One: Minor Single Married Divorced Widowed Separated

Patient's or Parent's Employer: _____ Work Phone #:_____

If Patient is a Student, Name of School: _____ City: _____

Emergency Contact Name: _____ Phone #: _____

Name of Person Responsible For This Account (If other than patient): _____

Address: _____ Relationship to Patient_____

Employer: _____ Work Phone: _____ Home Phone:_____

Dental Insurance Information:

Name of Insured: _____ Relationship to Patient: _____

Name of Employer: _____ Birthdate: _____ SS#:_____

Insurance Co: _____ Group #: _____ Contract #: _____

Ins. Co. Address: _____ City: _____ St: ___ Zip: _____

Additional Dental Insurance:

Name of Insured: _____ Relationship to Patient: _____

Name of Employer: _____ Birthdate: _____ SS#:_____

Insurance Co: _____ Group #: _____ Contract #: _____

Ins. Co. Address: _____ City: _____ St: ___ Zip: _____

Welcome to our practice! How did you hear about us? _____

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NOTICE OF PRIVACY PRACTICES

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will not usually ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures may be:

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- When a state or federal law mandates that certain health information be reported for a specific purpose; for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices.
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence.
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws.
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- Uses or disclosures for health-related research;
- Uses and disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- Disclosures of de-identified information;
- Disclosures relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call, text or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we may email or mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

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OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Please send them directly to our office.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address or Email shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using Email to your personal Email address. We will accommodate any reasonable request. If you want to ask for confidential communications, send a written request to the office contact person at the address or Email shown at the beginning of this Notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 5 business days of asking us (or 30 days if the information is archived off-site). Since 2014 our radiographs have been obtained and stored digitally. Therefore, transfer of these images and/or chart information will be through Email. You will either be asked to provide a secure Email address or waive the right to privacy in the event that your information is breached due to an insecure Email system. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we are allowed one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address or E mail shown at the beginning of this Notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 30 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you

specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address or Email shown at the beginning of this Notice.

- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address or Email shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, please call us or send a written request to the office contact person at the address or Email shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address or Email shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

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FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of CrossKeys Dental's Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____

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Payment for Services

We have several financial options available to work out a solution for your particular situation. We have found that our patients appreciate knowing their exact financial responsibilities. With this in mind, we inform our patients of any fees and possible financial arrangements before treatment begins so that you can arrange for payment for appropriate care. We are dedicated to providing the best possible care and we want you to completely understand our payment policies and options.

- So that we both have a definite understanding, before beginning treatment please select the payment option that is most appropriate for you:
  1) **Accounting Reduction:** A 5% accounting reduction will be extended to all patients when fees in excess of $500 are paid prior to or on the day of your scheduled appointment.
  2) **Major Credit Card:** We accept Visa, Master Card, Discover, and American Express.
  3) **Extended Payment Plans:** Plans based upon credit approval, often with no-interest terms.
  4) **For preventive and minor restorative (fillings):** Payment is due at the time of treatment. For patients with insurance coverage, this means that your out of pocket portion, which we will estimate to the best of our abilities, will be due at this time.
  5) **For Major restorative (e.g. crowns, bridges, dentures):** 50% of your out of pocket fee is due at the time that the work is started, and the remainder is due when the final product is completed and delivered to you. Again, we will do our best to accurately estimate your insurance coverage.
- **Insurance**: We are participating providers for Excellus BC/BS. We also submit claims for most major insurance plans. If you are insured by a plan that our office works with but are not able to provide an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. There are many insurance plans. We will assist you with learning about your plan, but knowing your insurance coverage is your responsibility. Please contact your insurance company with any questions regarding your coverage. Please understand that your insurance coverage is based upon a contract that you or your employer have with the insurance company (e.g. Excellus). We are not a party in said contract and have no influence over their fees.
- **Co-Payments and Deductibles:** These must always be paid at the time of service. This arrangement is a part of your contract with your insurance company. We accept payment as noted above. You may be billed an additional co-pay depending upon your insurance coverage.
- **Non-Covered Services:** Be aware that some, and in some cases all, of the services that you receive may not be covered by your insurance plan. In some cases (e.g. cosmetic dentistry) the treatment that you choose may even be deemed unnecessary by your insurer. These services require payment in full at the time of your treatment.
- **Proof of Insurance:** All new patients must complete our registration form before their exam. We must obtain a copy of a valid insurance card to verify proof of insurance. If you fail to provide us with the correct insurance information in the time required to meet your insurance company claim filing limit you will be responsible for the balance of the claim.
- **Claim Submission:** We will submit all claims and help in any reasonable way to be sure that you are paid for your claims. Your insurance company may request information directly from you

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and it is your responsibility to comply with their request. Please be aware that you balance is your responsibility whether or not your insurance provider pays for your claim. Your insurance benefits are a contract between and your insurance provider. We are not a party to that contract.

- **Coverage Changes:** If your insurance coverage changes please notify us so that we can update our system to help you receive your maximum benefits.
- **Non-payment**: If your account is past due you will receive an invoice stating that payment in full is required upon receipt. We cannot accept partial payments, but we can certainly arrange financing for you though Care Credit. Please be aware that past due accounts will be subject to referral to a collection agency and you may be discharged from the practice. If this occurs you will be notified through certified mail that you have 30 days to find a new dental care provider.

Our practice is dedicated to quality care. Our fees are representative of the usual and customary charges for dental service in this region. Please let us know if you have any questions or concerns regarding these fees.

I understand that the doctor may discover other or different conditions that may require additional or different procedures than were originally planned. I authorize that these procedures are deemed necessary to complete the treatment in the doctor's professional judgement. The doctor will be sure that you understand any new requirements at the time of service, allowing you the opportunity to take part in the decision-making process at that time. The fee will be adjusted accordingly.

I have read and understand the payment policies of CrossKeys Dental. I acknowledge that I am financially responsible for the services provided regardless of insurance coverage.

Signature of patient (or responsible party) Date

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MEDICAL HISTORY FORM – Please use the back of the sheet if additional space needed -

Patient Name: Date of Birth: Today's Date:

Health problems you have, or medication you take, could affect your dental health. Thank you for answering these questions as accurately as possible.

Do you have a Primary Care Physician?	Yes	No	Name	
Their phone #				
Do you regularly see a medical Specialist?	Yes	No	Name	
Their Phone #				

Are you currently being treated by a physician?	Yes	No	For what?	
Have you ever been hospitalized or had a major surgery?	Yes	No	Describe	
Have you ever had a serious head or neck injury?	Yes	No	Describe	
Are you taking any medication, pills or drugs?	Yes	No	Describe	
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	Describe	
Have you ever taken Fosamax, Boniva, Actonel or any other bisphosphonates?	Yes	No	Describe	
Are you on a special diet?	Yes	No	Describe	
Do you use any tobacco products?	Yes	No	Describe	

Women: Are you…

☐ Pregnant or trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Dental Anesthetics

☐ Metals ☐ Latex ☐ Sulfa Drugs ☐ Acrylic

Any other allergies?	Yes	No	Describe	
Do you use controlled substances?	Yes	No	Describe	

Do you have, or have you had, any of the following conditions diagnosed? Please check all that apply and explain in the comments below.

- ☐ AIDS/ HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety/Depression
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Condition
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting/Dizzy Spells
- ☐ Frequent Coughs
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Anemia
- ☐ Sinus Issues
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had a serious illness that is not listed above? If so, describe here:

Please use this box to elaborate on the conditions selected above or to make any other additional 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 (the patient's) health. It is my responsibility to inform CrossKeys Dental of any changes in my (the patient's) medical status.

Signature of Patient or Guardian _____ Date _____