Welcome to CitiDental

Date: _____

Patient Information:

Name_____ D.O.B._____ SS#_____

Address_____ Apt_____

Town_____ State_____ Zip_____ Marital Status_____

Home Phone_____Cell#_____ Other_____

Email_____

Employer_____ Work Phone_____

EMERGENCY CONTACT: Name_____Phone_____

Responsible Party: (if different from above)
Name_____ Address_____
SS#_____ Birth date_____

Whom May we thank for this referral? (current patient, Yellow Pages, website, etc)
_____

Dental Insurance Information: check if does not apply ____

Name of person carrying insurance_____

Insurance Company Name_____

Insurance ID # **or** social security #_____

Insured's D.O.B_____

Group Number_____

Insured employer name_____

Do you have another dental insurance?_____

Dental History:

How can we help you today?_____

Former Dentist's Name:_____ Date of last dental visit?___ _____

How often do you brush?_____ How often do you floss?_____

PLEASE CHECK ALL THAT APPLY:

Y or N	Bad Breath	Y or N	Food Collects between teeth	Y or N	Pain around ear
Y or N	Bleeding Gums	Y or N	Foreign Objects	Y or N	Periodontal Treatment
Y or N	Blisters on lips/mouth	Y or N	Grinding teeth	Y or N	Sensitivity to cold
Y or N	Burning on Tongue	Y or N	Gums swollen or tender	Y or N	Sensitivity to hot
Y or N	Chew on one side of mouth	Y or N	Jaw pain or tiredness	Y or N	Sensitivity to sweets
Y or N	Cigarette or cigar smoking	Y or N	Lip or cheek biting	Y or N	Sensitivity when biting
Y or N	Clicking or popping jaw	Y or N	Loose teeth/broken fillings	Y or N	Sores in mouth
Y or N	Dry mouth	Y or N	Mouth breathing	Y or N	Orthodontic Treatment
Y or N	Fingernail biting	Y or N	Mouth pain		

Patient Name_____ **Date_____**

Please answer the following questions:

1. Have you ever taken pre-medication (antibiotics) before dental visits? Y or N
2. Have you had any periodontal treatment (gum treatment) in the past? Y or N
3. Do you have sensitivity to hot, cold, sweets or when chewing? Y or N
4. Do you take Aspirin (Bayer, Bufferin) on a regular basis? Y or N
5. Have you ever taken Bisphosphonates (Fosamax, Boniva, Actonel)? Y or N
6. Have you ever been diagnosed with a problem with either jaw joint? Y or N
7. Does your jaw click, pop, or make noise when you open and close? Y or N
8. Is there pain or tenderness in your jaw joint when you open, close or chew? Y or N
9. Has your jaw ever locked open or closed? Y or N
10. Do you have frequent headaches? If so how often? _____ Y or N
11. Do you clench or grind your teeth, or ever been told you do? Y or N
12. Have you ever had trauma to your chin or jaw? Y or N

Medical History:

Physician's Name_____ Date last visit? (approx) _____

Additional Specialist doctors:_____ Date of last visit?_____

Please circle Y (yes) or N (no) for ALL medical conditions listed below:

Y or N	Aids/HIV	Y or N	Jaundice	Y or N	Blood Disease
Y or N	Cortisone Treatments	Y or N	Sinus Trouble	Y or N	Glaucoma
Y or N	Heart Problems	Y or N	Artificial pins, joints	Y or N	Mitral Valve Prolapse
Y or N	Respiratory Disease	Y or N	Diabetes	Y or N	Thyroid Problems
Y or N	Anemia	Y or N	Kidney Disease	Y or N	Cancer
Y or N	Circulatory Problems	Y or N	Stroke	Y or N	Headaches
Y or N	Hepatitis (type____)	Y or N	Asthma	Y or N	Pacemaker
Y or N	Rheumatic Fever	Y or N	Epilepsy	Y or N	Tumors or growths
Y or N	Arthritis	Y or N	Liver Disease	Y or N	Chemical Dependency
Y or N	Congenital Heart Lesions	Y or N	Skin Rash	Y or N	Heart Murmur
Y or N	High Blood Pressure	Y or N	Abnormal Bleeding	Y or N	Radiation treatment
Y or N	Scarlet Fever	Y or N	Fainting/dizziness	Y or N	Ulcers
Y or N	Artificial Heart Valves	Y or N	Low Blood Pressure	Y or N	Venereal Disease
Y or N	Persistent cough	Y or N	Swollen neck glands	Y or N	Weight Loss, unexplained
Y or N	Psychiatric disorders	Y or N	Depression	Y or N	Herpes

Women: Are you Pregnant ____ Nursing ____ Taking Birth Control Pills? _____

Have you ever taken any group of drugs that are affiliated with Fen-phen? Yes or No

Please List **ALL** medications you are taking, the amount and frequency for each: _____

_____ _____

_____ _____

_____ _____

Allergies: Do you have any allergy to any of the following OR medication? Please circle any that apply

Latex	Aspirin	Barbituates (sleeping pills)
Penicillin	Codeine	Iodine
Sulfa	Local Anesthetic	Other_____

SIGNATURES: Please sign below:

PATIENT or guardian _____ ____/____/____ DOCTOR/R.D.H_____ ___/___/___

CITIDENTAL

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 health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/03), 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 make the new Notice available 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 for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician 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. 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 treatment, payment or healthcare operations, 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.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) 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 incapacity or 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. We will also use our professional judgment and our experience with common practice to make

reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. 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: 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.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing.)** Your request must specify the alternative means or location, and provide satisfactory explanation 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: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

CitiDental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You may refuse to sign this Acknowledgement****

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

_____
Please print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices. Acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (please specifiy)

_____

_____

Attention Insured Patient,

In order to submit claims accurately, the following are needed:

1. We need all necessary information on the policy holder.

2. Information does need to be verified by the insurance company.

Note:

Information provided by the insurance company **IS NOT A GUARANTEE OF BENEFITS**, only *an* ***estimation*****.** Please review your policy book so there are no misunderstandings. If you do not have a policy book, contact your human resource office.

You, the patient, are responsible for your own policy, we are third party billing only, and given minimal information by your insurance company.

You are responsible for all co-pays at time of service, and any balance that may occur after the insurance has paid. We do send dental pretreatment estimates to your insurance if treatment is diagnosed and discussed. This is done to have approval on file if treatment is rendered. It is NOT submitted for reimbursement until actual services are performed.

OUR GOAL:

To give you the best estimate possible with the information given to us by your insurance company**. Until the insurance company receives the actual CLAIM, it remains an ESTIMATE and not a GUARANTEE.** TREATMENT PLANS AVAILABLE.

By signing below,

I authorize direct payment of the insurance benefits to CitiDental and its' associate doctors, for treatment rendered to me and/or my child/children.

I have read and understand the above policies.

Patient/parent/guardian_____Date_____

Office Policies Of CitiDental

FINANCIAL AGREEMENT: ***Payment is due at time of service***

Financial assistance is available, upon credit approval.

As a courtesy to you, we will submit all charges to the insurance company. Insurance is designated to cover a portion of the customary fee. Co-payments are collected at time of visit. (Please see our insurance policies.)

BALANCES LEFT ON ACCOUNT FOR OVER 60 DAYS: All parties will be responsible for the cost of collection, which may include but is not limited to any and all collection and legal fees.

Returned checks: There will be a $25.00 fee. **Initial_____**

CANCELLATION AND FAILURE TO ARRIVE:

We understand that circumstances do arise that can keep you from a dental appointment. Please, have the courtesy to give the office 72 hours notice. Please understand that we have reserved the doctors time for you and we will try to contact you at all phone numbers listed to confirm your appointment.

There will be a $75.00 charge for all appointments missed or cancelled without 72 hours notice.

Initial_____

To reserve a treatment appointment with one of our Specialists on Staff (perio or endo), there will be a deposit of $200.00 required at time of scheduling which is applied towards any dental co-payment. 72 hours notice needed for cancellation.

There will be a $200.00 charge for all specialist appointments missed or cancelled without 72 hours notice.

Initial_____

X-RAYS: Digital x-rays are the property of CitiDental. If you wish to have your x-rays emailed, a notice of 24 hours is necessary.

PRIVACY NOTICE:

Privacy Act: I give CitiDental permission to send reminder postcards to me through U.S. Postal Service, and to leave messages via answering machine, voicemail, e-mail, cell phone, or other family members.

By signing below, I understand the above listed policies, and assume responsibility for all services rendered.

Patient/Parent/Guardian_____Date_____