

Acknowledgement of Receipt of Notice of Privacy Practices

Please note: You may refuse to sign this acknowledgment.

I have received a copy of this office's notice of privacy practices.

Please Print Name

Signature

Date

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgement could not be obtained because:

- Individual refused to sign.
- Communication barrier prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other (*Please specify:*)

Patient Financial Acknowledgement Form

Our goal is to provide you with optimal care based on your individual needs. To assist you in receiving this care, we offer several payment options. You can choose to pay by cash, check, Visa, MasterCard, American Express or Care Credit*. Co-Payments and deductible are due at the time of your visit.

We offer no interest payment plans in addition to extended payment plans through Care Credit, a division of GE Consumer finance. Care Credit is a practical method of payment for those patients' who do not have insurance, as well as those who do as most treatment plans are not covered at 100% of your insurance plan schedule.

Please ask for a Care Credit brochure and our office staff will be glad to assist you with any information you need. All you have to do is fill out a quick and easy application. We have a decision within 5 minutes or less!!

I have read and full understand this financial acknowledgement form and my payment options.

Patient / Guardian Signature

Date



Thank you for choosing us for your dental needs.

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 this document carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) requires all health care records and other individually identifiable health information (PROTECTED HEALTH INFORMATION) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

***Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.

***Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be billing your dental plan for your dental services.

***Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protection information when we are required to do so by federal state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency of activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner

or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may also disclose your PROTECTED HEALTH INFORMATION to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety of the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs. Any other uses and disclosures will be made only with your written consent. You may revoke such consent in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your consent. You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our privacy officer at the practice address listed on this form:

*The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

*The right to request or receive confidential communication of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.

*The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.

*The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and healthcare operations.

*The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Michael J. Gulotta, DDS, PLLC
1150 Portion Road, Suite 15
Holtsville NY 11742
631-696-3820

For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll free)

Authorization Revocation Form

This notice revokes the authorization to the use and disclosure of PROTECTED HEALTH INFORMATION for:
Patient name that was signed on Date of Authorization.

Effect of Revocation

PROTECTED HEALTH INFORMATION that is collected on or after the date on which this form is received by Michael J. Gulotta, DDS, PLLC for the purposes specified in the authorization that is revoked. This revocation of authorization will not limit the ability of Michael J. Gulotta, DDS, PLLC to seek payment for services that it provided under an earlier authorization, nor to meet legal obligations related to those services, nor will it affect used or disclosures under the revoked authorization that occurred prior to the effective date of this revocation.

Other consequences of revoking authorization include: Effective Date of Revocation

This revocation of authorization to use or disclose PROTECTED HEALTH INFORMATION if effectiveEffective Date

Print Name of Patient

Address of Patient

Signature of Patient

Date

Registration and Health History

PATIENT INFORMATION	Name: _____		Date: _____	
	Address: _____			
	City: _____		State: _____	Zip: _____
	Home Phone: _____		Work Phone: _____	
	<input type="checkbox"/> Male	<input type="checkbox"/> Single	<input type="checkbox"/> Married	Birth date: _____
	<input type="checkbox"/> Female	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
	SS#: _____			Relationship: _____
PRIMARY DENTAL INSURANCE INFORMATION	<i>In case of emergency, please contact:</i>			
	Name: _____		Relationship: _____	
	Phone: _____			
	<i>Whom may we thank for referring you?</i>			
	Member Name: _____			
	Date of Birth: _____	SS#: _____	Relationship to Patient: _____	
	Address (If different than patient): _____			
City: _____		State: _____	Zip: _____	
Insurance Company: _____		Group# _____		
Insurance Co. Address: _____		Phone Number: _____		
Member's Employer: _____				
Employer Address: _____		Employer's Phone: _____		
SECONDARY DENTAL INSURANCE INFORMATION	Is Patient covered by additional dental insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please complete the following:</i>			
	Member Name: _____			
	Date of Birth: _____	SS#: _____	Relationship to Patient: _____	
	Address (If different than patient): _____			
	City: _____		State: _____	Zip: _____
	Insurance Company: _____		Group# _____	
	Insurance Co. Address: _____		Phone Number: _____	
Member's Employer: _____				
Employer Address: _____		Employer's Phone: _____		
ASSIGNMENT OF BENEFITS RELEASE:	I, the undersigned, certify that I (or my dependent) have insurance with _____ and assign directly to Dr. Gulotta all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions:			
	_____ Responsible Party Signature		_____ Relationship to Patient	_____ Date

DENTAL HISTORY

Reason for today's visit: _____

Former Dentist: _____

Date of last dental visit: _____

Date of Last Dental X-Rays: _____

Do you have any of the following:

Bad Breath: Yes No
Bleeding Gums Yes No
Blisters on Lips or Mouth Yes No
Burning Sensation on tongue..... Yes No
Chew on 1 side of mouth..... Yes No
Clicking or Popping jaw Yes No
Dry mouth..... Yes No

Grinding Teeth Yes No
Jaw Pain..... Yes No
Lip or Cheek Biting Yes No
Loose Teeth or Broken Fillings Yes No
Mouth Breathing Yes No
Mouth Pain when breathing Yes No
Orthodontic work..... Yes No

Pain in Ear..... Yes No
Periodontal Treatment..... Yes No
Sensitivity to Cold Yes No
Sensitivity to Heat Yes No
Sensitivity to Sweets..... Yes No
Smoker Yes No
Sores or Growths in Mouth Yes No

How often do you brush? _____

How often do you floss? _____

HEALTH HISTORY

Physician's Name: _____

Date of Last Visit: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Lonimin, Adipex, Fastin (brand names of phentermine) Pondimin (fenfluramine) and Redux (dexfejluramine).

Yes No

Check Yes or No if you have had any of the following:

AIDS/HIV Yes No
Anemia..... Yes No
Arthritis..... Yes No
Artificial Heart Valves..... Yes No
Artificial Joints Yes No
Asthma..... Yes No
Back Problems Yes No
Bleeding abnormally with
extractions or Surgery Yes No
Blood Disease Yes No
Cancer Yes No
Chemical Dependency Yes No
Chemotherapy..... Yes No
Circulatory Problems Yes No
Congenital Heart Disease Yes No
Cortisone treatments Yes No
Cough, Persistent/Bloody..... Yes No
Contact Lenses..... Yes No

Epilepsy..... Yes No
Fainting/Dizziness..... Yes No
Glaucoma..... Yes No
Headaches..... Yes No
Heart Murmur..... Yes No
Heart Problems..... Yes No
Hepatitis Type Yes No
Herpes Yes No
High Blood Pressure..... Yes No
Jaundice..... Yes No
Kidney Disease..... Yes No
Liver Disease Yes No
Low Blood Pressure Yes No
Mitral valve prolapse..... Yes No
Nervous Problems Yes No
Pace Maker..... Yes No
Ulcer..... Yes No
Radiation treatment Yes No

Respiratory disease..... Yes No
Rheumatic Fever Yes No
Scarlet Fever..... Yes No
Shortness of Breath..... Yes No
Sinus trouble Yes No
Skin rash..... Yes No
Special diet..... Yes No
Spina Bifida Yes No
Stroke Yes No
Swollen fee/ankles..... Yes No
Swollen neck glands..... Yes No
Thyroid problems..... Yes No
Tonsillitis..... Yes No
Tuberculosis..... Yes No
Tumors or growths on
head or neck Yes No
Venereal disease..... Yes No

ALLERGIES:

Aspirin Yes No
Codiene..... Yes No
Local Anesthetic..... Yes No

Lastex Allergy Yes No
Penicillin Yes No
Barbituates..... Yes No

Sulfa..... Yes No
Avocados, bananas, chestnuts, hazelnuts,
kiwis, potatoes or tomatoes?... Yes No

Do you wake up multiple times at night to change your
clothing or bedding due to unusually heavy perspiration? Yes No
Can you blow up balloons? Yes No
Do you have a history of repeated surgeries in childhood? Yes No

WOMEN

Are you pregnant? Yes No Due Date: _____
Are you nursing? Yes No
Taking birth control? . Yes No

MEDICATIONS:

List any medications you are taking: _____

Pharmacy name: _____

Pharmacy Phone #: _____

In order to properly diagnose and treat dental problems we require and it is recommended by the American Dental Association that a full mouth series of X-rays or Panorex be taken every 3-5 years.

_____ I agree to this treatment

_____ I hereby waive the need for this treatment and fully understand the risks involved with not having routine dental X-rays

Patient/Guardian Signature _____

Date _____

We thank you for choosing us for your dental care needs.

In order to provide quality care for our patients, we set an ample amount of time aside for you. In the event you must cancel an appointment, we will require at least 24 hours notice. We reserve the right to assess a fee if notice is not given or if you fail to show up for an appointment without any notice. We are here for you, so please be here for us!! _____ Patient Initial