Dr. Dorian Tetelman

115 EAST 61ST STREET #8D
NEW YORK, NY
•10065•

DENTAL REGISTRATION AND MEDICAL HISTORY / MEDICAL UPDATE

Name (last)_____ (first)_____(mi) _____ Date of Birth_____

Home Address_____apt_____City _____ State_____ Zip_____

Home phone #_____Cell phone #_____Work phone #_____

Social Security Number _____ Male___Female___ Other ___ Email address_____

Occupation_____Employer_____Referred by _____

In Case of emergency (name) _____Relationship_____Phone #_____

Dental Insurance:

Insurance Co._____Subscriber Name_____DOB_____

Relationship to patient_____Policy #_____Group #_____

Is the patient covered by additional insurances? Yes _____ No_____

If yes, Subscriber's Name _____Relationship to patient_____

Dental History: Date Last Dental Visit:_____Date last dental x-rays:_____Reason for today's visit:_____

Bad Breath	Yes	No	Lip or cheek biting	Yes	No	Sensiticity to cold	Yes	No	How often do you floss?
Bleeding gums	O	O	Loose teeth or broken fillings	O	O	Sensitivity to heat	O	O	_____
Cigarette,pipe	O	O	Orthodontic traetment	O	O	Sensitivity to sweets	O	O	How often do you brush?
Dry mouth	O	O	Pain around ear	O	O	Sensitivity when biting	O	O	_____
Jaw pain or tiredness	O	O	Periodontal treatment	O	O	Sornes or growths	O	O	

Medical History:

Physician's Name:_____ Date of last Visit_____

Cross on "yes" or "no" to indicate if you have had any of the following:

AIDS/ HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatment	Yes	No
Alzeimer's Disease	O	O	Diabetes	O	O	Hepatitis A	O	O	Recent Weight Loss	O	O
Anaphylaxis	O	O	Drug Addiction	O	O	Hepatitis B or C	O	O	Renal Dialysis	O	O
Anemia	O	O	Easily Winded	O	O	Herpes	O	O	Rheumatic Fever	O	O
Angina	O	O	Emphysema	O	O	High Blood Pressure	O	O	Rheumatism	O	O
Arthritis / Gout	O	O	Epilepsy or Seizures	O	O	High Cholesterol	O	O	Scarlet Fever	O	O
Artificial Heart Valves	O	O	Excessive Bleeding	O	O	Hives or rash	O	O	Shingles	O	O
Artificial Joint	O	O	Excessive Thirst	O	O	Hypoglycemia	O	O	Sickle Cell Disease	O	O
Asthma	O	O	Fainting Spells/ Dizziness	O	O	Irregular Heartbeat	O	O	Sinus Trouble	O	O
Blood Disease	O	O	Frequent Cough	O	O	Kidney Problems	O	O	Spina Bifida	O	O
Blood Transfusion	O	O	Frequent Diarrhea	O	O	Leukemia	O	O	Stomach/ Intestinal Disease	O	O
Breathing Problems	O	O	Frequent Headaches	O	O	Liver Disease	O	O	Stroke	O	O
Bruise Easily	O	O	Genial Herpes	O	O	Low Blood Pressure	O	O	Swelling of Limbs	O	O
Cancer ..... Yes / no	O	O	Glaucoma	O	O	Lung Disease	O	O	Thyroid Disease	O	O
Chemotherapy	O	O	Hay Fever	O	O	Mitral Valve Prolapse	O	O	Tonsillitis	O	O
Chest Pains	O	O	Heart Attack/ Failure	O	O	Osteoporosis	O	O	Tuberculosis	O	O
Cold Sore/ Fever Blisters	O	O	Heart Murmur	O	O	Pain in Jaw Joints	O	O	Tumors or Growths	O	O
Congenital heart Disorder	O	O	Heart Pacemaker	O	O	Parathyroid Disease	O	O	Ulcera	O	O
Convulsions	O	O	Heart Trouble/ Disease	O	O	Psychiatric Care	O	O	Venereal Disease	O	O
									Yellow Jaundice	O	O

Allergies: Penicillin (Yes / No) Local Anesthetic (Yes / No) Codeine (Yes / No) Latex (Yes / No) Other:_____

Medications: List medications you are currently taking_____

Women: Are you pregnant? (yes / no) Nursing (Yes / No) Taking birth control pills (Yes / No)

To my best of my knoledge, the questions on this forms have beed accurately answerd. I undertand that providing incorrect infromation can be dangerous to my health. It is my responsability to inform the dental office of any changes in medical status.

I authorize my insurance company to pay to the dentis group all insurance benefits otherwise payable to me for the service rendered.

I authorize the use of this signature on all insurance submission.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I undertand that I am financially respossible for all charges whether or not paid by insurance.

I undertand a charge may incur if 48 hours notice is not given an a cancelation.

Signature _____Name _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

NOTICE OF PRIVACY PRACTICES AND TREATMENT CONSENT FORM

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Please review carefully : **Uses and disclosures of protected health information (PHI)**

- **TREATMENT** means providing coordination or managing health care and related services by one or more health care providers. Examples of this would include teeth cleaning services, ordering a prescription from pharmacy and consultation and/ or referral to a specialist.
- **PAYMENT** means such activities as obtaining reimbursement of services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **HEALTH CARE OPERATIONS** includes the business aspect of running our practice , such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer services. Example would be an internal quality assessment review and the use of sign-in sheet at the registration desk.

We may also create and distribute de-identified health information by removing all references to individual information.

We may concontact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other and disclosures will be made only with your writing authorization, You may revoke such authorization in writing and we are required to honor or abide by that writing request, except to the extent that we have already taken actions relying on your authorizations.

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. These include

- The right to request restriction on the use and disclosure of your health information.
- The right to receive confidential communication concerning your health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

This notice is effective on or April 2003 and 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 OR PRIVACY PRACTICE AND TO MAKE THE NOTICE PROVISIONS EFFECTIVE FOR ALL PROTECTED HEALTH INFORMATION THAT WE MAINTAIN.** We will post and you may request a writing copy of a Revised Notice of Policy Practices from this office.

You may recourse if you feel that your privacy protection has been violated. You have the right to file a complaint with our office, or with the department of Health and Human Services, office of Civil Rights, about violations of the provisions of this notice or the police and procedures of our office.

By signing this document, you acknowledge that you have read and understand these policies.

_____	_____	_____
Print Patient Name	Relationship to patient	Date

Dr. Dorian Tetelman
115 East 61St Street , Suite 8D
New York NY 10065
212-319-0090
dentaleast60@gmail.com

Appointment Cancellation Policy

We Understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for a scheduled appointment to be cancelled at least 24 hours in advance.

Our doctors and hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen.

We have revised our cancelation policy, appointments not cancelled by the previous business day will be subject to a **$50.00** broken appointment fee.

Thank you for being a valued patient and for your understanding and cooperation with this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

The Staff of Dr. Dorian Tetelman and Associates

Patient Signature _____ Date: _____