# Contemporary Dentistry, PLLC

Arlene Messer, DDS ● Anna V. Belous, DDS ● Robert Calcagno, DDS

## PATIENT REGISTRATION

Patient Name _____ Birth Date _____ SS # _____
(If a child) Parent's Name _____ Birth Date _____ SS# _____
Marital Status: Single □ Married □ Significant Other □ Divorced □ Separated □ Widowed □
Address _____ City_____ State _____ Zip_____
Home # _____Work # _____ Ext _____ Cell # _____
Email Address _____
Hobbies/Interests _____

Patient employed by _____ Present position _____
Business address _____ City_____ State _____ Zip _____
Are you a full time student? _____ Name of school _____

Purpose for this appointment _____
Who may we thank for referring you? _____
Are any of your family members patients at our practice? _____

Spouse's Name_____ Birth Date _____ SS# _____
Spouse employed by _____ Present position _____
Business address _____ City _____ State _____ Zip _____

**In case of emergency, who should we contact?** _____ Phone # _____

**Primary Dental Insurance Information:**
Name of insured _____ Birth date _____ Relationship to patient_____
Primary insurance company _____ Policy # _____ Group # _____
Address _____ City _____ State _____ Zip _____
Insurance company phone # _____

**Secondary Dental Insurance Information:**
Name of insured _____ Birth date _____ Relationship to patient_____
Primary insurance company _____ Policy # _____ Group # _____
Address _____ City _____ State _____ Zip _____
Insurance company phone # _____

**Patient Medical/Dental Information:**

1. When was your last dental visit? _____
2. Does dental treatment make you nervous?..... Yes No
3. Are you having any discomfort at this time?..... Yes No
   Where? _____
4. Are you interested in whitening your teeth?..... Yes No
5. Are you interested in finding out more about cosmetic Dentistry? ..... Yes No
6. Have you had orthodontic treatment? ..... Yes No
7. Do you get headaches, jaw, neck or shoulder pain, or have you had TMJ issues in the past? ..... Yes No
8. Do you have or have you ever had any of the following: Please circle what applies
9. Clicking or popping of jaw..... Yes No
10. Difficulty opening or closing jaw..... Yes No
11. Clenching/grinding/shifting in bite..... Yes No
12. Bleeding or sore gums..... Yes No
13. Sensitivity to hot, cold, sweets, or biting..... Yes No

# Eaglesoft Medical History(Copy)(Copy)

Patient Name: Birth Date: Date Created:

| | | |
|---|---|---|
| Are you under a physician's care now? | Yes No | If yes |
| Have you ever been hospitalized or had a major operation? | Yes No | If yes |
| Have you ever had a serious head or neck injury? | Yes No | If yes |
| Are you taking any medications, pills, or drugs? | Yes No | If yes |
| Do you take, or have you taken, Phen-Fen or Redux? | Yes No | If yes |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | Yes No | If yes |
| Are you on a special diet? | Yes No | If yes |
| Do you use tobacco? | Yes No | If yes |
| Do you use controlled substances? | Yes No | If yes |

Are you allergic to any of the following?

| | | | |
|---|---|---|---|
| Aspirin | Penicillin | Codeine | Acrylic |
| Metal | Latex | Sulfa Drugs | Local Anesthetics |

Other? If yes

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

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

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

Have you ever had any serious illness not listed above? Yes No If yes

Sleep Questions: Do you have/Have you ever been told....

| | | |
|---|---|---|
| Sleep apnea Yes No | Daytime sleepiness Yes No | Do you snore Yes No |
| CPAP/oral sleep device Yes No | That you need a sleeping device Yes No | Stop breathing while asleep Yes No |

Physician Information: Name/address/phone number

| | | |
|---|---|---|
| Name of Physician | | If yes |
| Address | | If yes |
| Phone number | | If yes |

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

# Contemporary Dentistry, PLLC

Arlene Messer, DDS ● Anna V. Belous, DDS ● Robert Calcagno, DDS

## Financial Agreement and Disclosure Notice

The undersigned or responsible party agrees that the following terms will govern the payment of professional services rendered by our office and charged to his/her account.

1. Undersigned agrees to pay the balance of his/her account when services are rendered.
2. If the undersigned has dental insurance, we will accept assignment of insurance benefits, if allowed by your insurance company.
    A) If assignment of benefits is not allowed by your insurance company, then payment is due as the services are rendered.
    B) Undersigned's estimated share of fee is due at the time of service, if insurance benefit is assigned to our office.
    C) Undersigned understands and accepts that he/she is responsible for the entire fee regardless of what insurance pays.
3. In the event undersigned fails to pay the balance within 60 days of the date of service, A FINANCE CHARGE of 1½% per month (annual percentage rate 18%) shall be calculated on the unpaid amount which is more than 60 days overdue.
    A) We have the option of deleting any finance charge, if the account is paid in full within 10 days of statement date.
    B) We will incur minimum billing/finance charge of $3.00 to those accounts due past 60 days.
4. Undersigned MAY AVOID a finance charge by paying the new balance in full as outlined above.
5. Any check that is returned to our office for insufficient funds will incur a $30 fee.
6. Undersigned on a monthly payment plan will be charged the minimum billing/finance charge on any amount owed 60 days beyond the initial billing date.
7. Appointments cancelled with less than 24 hours notice are subject to charge. The charge will be dependent on the length of the appointment. Typically a broken hygiene appointment will incur an $85.00 fee and a broken doctor appointment will incur a fee of $250.00/hour.
8. The Undersigned agrees to pay, to the extent permitted by law, all reasonable attorney fees and collection costs in the event that the unpaid balance of the undersigned's account is referred to an attorney or a collection agency.

The Undersigned or responsible party acknowledges that he/she has read and understands the information above and that a copy of this statement may be received upon request.

Signature of Patient or Responsible Party (if under 18 years of age) _____

Printed Name _____ Date _____

Comments:_____

_____

_____

# Contemporary Dentistry, PLLC

Arlene Messer, DDS ● Anna V. Belous, DDS ● Robert Calcagno, DDS

## Dental Fear Screening Information

Do you get sweaty palms just thinking about going to the dentist? Do you feel strange or different because you have a great fear of dentistry? Don't worry – you have lots of company! Studies show that 50% of the population avoids the dentist, usually because they are afraid. In our office, we will try to help you to overcome your fear. We care very much about every fearful patient who has had a bad dental experience. You may be surprised that today's dentistry can be compassionate and caring. There are many things that can be done for the person who has fear of dentistry. To allow us to better understand the source of your fear, please help us by answering the next few questions.

1. As a child, did you ever have a bad dental experience? If so, please describe it.
   _____
   _____
2. As an adult, did you ever have a bad dental experience? If so, please describe it.
   _____
   _____
3. Are you afraid of needles? If yes, please tell us why.
   _____
   _____
4. Are you afraid you may be hurt during the "drilling"? Please explain.
   _____
   _____
5. Does the sound/noise of the drilling bother you? _____
   Did you know that you can wear headphones during the dental procedure to eliminate this noise? Would you like to try this? (There is no charge for this service) _____
6. Did you know that a novacaine injection can be relatively painless? _____
   By applying a cream on the gum before injection, the surface of the gum becomes numb so that you don't feel the needle. By injecting the novacaine slowly and gently, you feel a small amount of pressure and that is all.
7. Does the swollen, numb feeling in your lips and tongue bother you? _____
   If so, we can use, in certain situations, a special syringe which will numb only your tooth and leave your lip and tongue feeling normal.
8. What are your greatest fears about dentistry?
   #1 Greatest fear _____
   #2 Greatest fear _____
   #3 Greatest fear _____

If you have any other fears or concerns, please tell us. We'd love to help you. We make every effort to provide dental treatment in a relaxed, caring environment. If you have additional questions or comments, please jot them below.

_____
_____
_____
_____
_____

**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**

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe in this notice while it is in effect. This notice takes effect April 14, 2003 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 applicable law permits the changes. 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 health care operations. For example:

**Treatment**: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

**Payment**: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

**Health Care Operations**: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation and certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operation s. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

**On Your Authorization**: 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 uses 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 may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best inter est. We may 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 fill ed prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

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

**Disaster Relief**: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

**Public Benefit**: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit.

- As required by law;
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight and to employers regarding work- related illness or injury;
- To report adult abuse, neglect or domestic violence;
- To health oversight agencies;
- In response to court and administrative orders and other lawful processes;
- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- To coroners, medical examiners and funeral directors;
- To an organ procurement organization;
- To avert a serious threat to health or safety;
- In connection with certain research activities;
- To the military and to federal officials for lawful intelligence, counter intelligence, and national security activities;
- To correctional institutions regarding inmates; and
- As authorized by state worker's compensation laws.

**PATIENTS 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 forma t 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 request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying cost s and postage. 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 may-but are not required to-prepare a summary or an explanation

of your health information for a fee. Contact us using the information listed at the beginning of this notice for more information about fees.

**Disclosure Accounting**: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. 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. Contact us using the information listed at the beginning of this notice for more information about fees.

**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). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request ls not binding unless our agreement is in writing.

**Alternative Communication**: You have the right request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location and provide satisfactory explanation how you will handle payment 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 we should amend the information. We may deny your request under certain circumstances.

**QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice. If you believe that:

- We may have violated your privacy rights;
- We made a decision about access to your health information incorrectly;
- Our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or;
- We should communicate with you by alternative means or at alternative locations

You may contact us using the information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Signature: _____

Print Name: _____

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## HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I authorize Contemporary Dentistry to use and disclose the protected health information described below to (individual person seeking information, such as spouse, relative, or friend) _____.

This authorization for release of information covers all past, present, and future periods of healthcare in this facility.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payments, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient: _____

Date: _____