MEDICAL HISTORY

Patient's Name____
Date of Birth_______________

Name of General Dentist______________________________________
Today's Date_______________

Please answer all questions by circling Yes or No.

1. Are you under the care of a physician at the present time? Yes No
2. Are you presently taking any medications? Yes No
3. Have you been told you have trouble with your heart? Yes No
4. Has a physician ever told you that you have high blood pressure? Yes No
5. Have you ever had rheumatic fever? Yes No
6. Have you had or do you now have AIDS, Hepatitis, or other infectious disease? Yes No
7. Do you have allergies? Yes No
8. Are you allergic to any drugs? Yes No
9. Do you have diabetes (sugar disease)? Yes No
10. Do you have any bleeding problems? Prolonged bleeding following tooth infections or cuts? Yes No
11. Have you had previous extractions with local anesthetic (shots) or general anesthesia (gas)? If so, please underline the appropriate word. Yes No
12. Have you had any trouble when you have had a tooth removed? Did you have prolonged bleeding, excess swelling, pain, infection, or other? If so, please underline the appropriate word. Yes No
13. Have you ever been treated with steroids, cortisone, or radiation (x-ray therapy)? Yes No
14. Have you ever had venereal disease (bad blood)? Yes No
15. Have you ever had any operations or major surgery, serious illness or been hospitalized for any length of time? Yes No
16. Are you pregnant? Yes No
17. Do you have a heart murmur? Yes No
18. Do you have any prosthetic joints or heart valves? Yes No
19. Have you ever had tuberculosis, asthma, or other lung troubles, yellow jaundice, liver trouble, gall bladder trouble, anemia, or epileptic convulsions, "fits," or seizures? Yes No

20. Are there any other problems with your health that you are aware of? Yes No

21. Has it been more than six months since your last visit to the dentist for a cleaning and exam? Yes No

Address and Phone Number of General Dentist:

____

____

____

IMPORTANT: A change in your medical/dental status should be reported to the office as soon as possible!

To the best of my knowledge, all of these questions have been answered correctly.

SIGNATURE OF
PATIENT____DATE_________

SIGNATURE OF
PARENT____DATE_________

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)

☐ Statement of Actual Services – OR – ☐ Request for Predetermination/Preauthorization

☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION Insurance Company

3. Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)

7. Gender ☐ M ☐ F

8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number

10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION Policy holder Name

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)

14. Gender ☐ M ☐ F

15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION Patient Name

18. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)

22. Gender ☐ M ☐ F

23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

sign X

Patient/Guardian signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

sign X

Subscriber signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) ☐ Oral Image(s) ☐ Model(s) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box) ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. Provider ID

50. License Number

51. SSN or TIN

52. Phone Number ( ) –

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X

Signed (Treating Dentist) — Date

54. Provider ID

55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) –

58. Treating Provider Specialty

©American Dental Association, 2002

J515 (Same as ADA Dental Claim Form) – J516, J517, J518, J519

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

+HIPAA: 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. Changes On This Notice Will Not Be Honored.

We understand that information about you and your health is very personal and therefore, we will strive to protect your privacy as required by law. We will only use and disclose your personal health information as allowed by applicable law.

We are required by law to maintain the privacy of our patients' personal health information and to provide you with notice of our legal duties and privacy practices with respect to your personal health information. We are required to abide by the terms of this Notice of Privacy Practices so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice of Privacy Practices effective for all personal health information maintained by us. You may receive a copy of any revised notice at our doctors' office.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

The following categories detail the various ways in which we may use or disclose your personal health information. For each category of uses or disclosures, we will give you illustrative examples. It should be noted that while not every use or disclosure will be listed, each of the ways we are permitted to use or disclose information will fall into one of the following categories.

Your Authorization: Except as outlined below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the use or disclosure. This form will describe what information will be disclosed, to whom, for what purpose, and when. You have the right to revoke that authorization in writing, except to the extent we have already relied upon it.

Uses and Disclosures for Treatment: We will make uses and disclosures of your personal health information as necessary for your treatment. For instance, doctors, nurses, and other professionals involved in your care will use information in your medical record to plan a course of treatment for you that may include procedures, medications, tests, etc.

Uses and Disclosures for Payment: We will make uses and disclosures of your personal health information as necessary for payment purposes. For instance, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you or we may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: We will use and disclose your personal health information as necessary, and as permitted by law, for health care operations. For example, we may use your personal health information in order to conduct an evaluation of the treatment and services we provide, or to review the performance of our staff.

Persons Involved In Your Care: Unless you object, we may in our professional judgment disclose to a member of your family, a close friend, or any other person you identify, your personal health information to facilitate that person's involvement in caring for you or in payment for that care. We may use or disclose personal health information to assist in notifying a family member, personal representative or any other person that is responsible for your care of your location and general condition. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Fundraising: We may contact you, at times in coordination with your physician, to donate to a fundraising effort on our behalf. If we contact you for fundraising purposes, you will be provided with the opportunity to opt out of receiving any future solicitations.

Appointments and Services: We may use your personal health information to remind you about appointments or to follow up on your visit.

Health Products and Services: We may from time to time use your personal health information to communicate with you about treatment alternatives and other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures: We are permitted or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization. Subject to conditions specified by law:

- We may release your personal health information for any purpose required by law;
- We may release your personal health information for public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations;
- We may release your personal health information to certain governmental agencies if we suspect child abuse or neglect; we may also release your personal health information to certain governmental agencies if we believe you to be a victim of abuse, neglect, or domestic violence;
- We may release your personal health information to entities regulated by the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls;
- We may release your personal health information to your employer when we have provided health care to you at the request of your employer for purposes related to occupational health and safety; in most cases you will receive notice that information is disclosed to your employer;
- We may release your personal health information if required by law to a government oversight agency conducting audits, investigations, inspections and related oversight functions;
- We may use or disclose your personal health information in emergency circumstances, such as to prevent a serious and imminent threat to a person or the public;

- We may release your personal health information if required to do so by a court or administrative order, subpoena or discovery request; in most cases you will have notice of such release;
- We may release your personal health information to law enforcement officials to identify or locate suspects, fugitives or witnesses, or victims of crime, or for other allowable law enforcement purposes;
- We may release your personal health information to coroners, medical examiners, and/or funeral directors;
- We may release your personal health information if you are a member of the military for activities set out by certain military command authorities as required by armed forces services; we may also release your personal health information if necessary for national security, intelligence, or protective services activities; and
- We may use unsecured, unencrypted e-mail/texting services (AOL, gmail, Hotmail, AT&T, and/or similar providers) to communicate within our office, to others involved in your care, and with our patients and/or their parents/guardians.

RIGHTS THAT YOU HAVE

Access to Your Personal Health Information: Generally, you have the right to access, inspect, and/or copy personal health information that we maintain about you. Unless you are currently a patient in our hospital or during a scheduled appointment with a clinician, requests for access must be made in writing and be signed by you or your representative. We will charge you for a copy of your medical records in accordance with a schedule of fees established by applicable state law. You may obtain an access request form from the doctor’s office.

Amendments to Your Personal Health Information: You have the right to request that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction

request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. Please note that even if we accept your request, we may not delete any information already documented in your medical record. You may obtain an amendment request form from the doctor's office.

Accounting for Disclosures of Your Personal Health Information: You have the right to receive an accounting of certain disclosures made by us of your personal health information except for disclosures made for purposes of treatment, payment, and healthcare operations or for certain other limited exceptions. This accounting will include only those disclosures made in the six years prior to the date on which the accounting is requested but, in no event will include disclosures made prior to April 13, 2003. Requests must be made in writing and signed by you or your representative. Accounting request forms are available from the doctor's office.

Restrictions on Use and Disclosure of Your Personal Health Information: You have the right to request restrictions on certain of our uses and disclosures of your personal health information for treatment, payment, or health care operations. For example, you may request that we do not share your health information with a certain family member. A restriction request form can be obtained from the doctor's office or Guest Services department of the hospital you visited. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event we have terminated an agreed uporestriction, we will notify you of such termination.

Confidential Communications: You have the right to request communications regarding your personal health information from us by alternative means or at alternative locations and we will accommodate reasonable requests by you. You must request such confidential communication in writing to each department to which you would like the request to apply.

Paper Copy of Notice: As a patient you retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means. Our Notice may also be obtained on our website at http://tribecateeth.com.

ADDITIONAL INFORMATION

Complaints: If you believe your privacy rights have been violated, you may file a complaint in writing with the health care provider, Dr. Ken Cooperman. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington D.C. 20201. All complaints must be made in writing and in no way will affect the quality of care you receive from us.

For further information: If you have questions or need further assistance regarding this Notice of Privacy Practices, you may contact Dr. Ken Cooperman at 88 Chambers Street, Suite 101, New York, NY 10007. 212-233-8320.

Effective Date: This Notice of Privacy Practices is effective May 5, 2008.

Written Acknowledgement

I acknowledge that I have reviewed the **Notice of Private Practice**, which provides a description of information uses and disclosures. I understand that I have the right to request restrictions to how my health information may be used or disclosed and the organization is not required to agree the restrictions I request.

____
Signature of Patient or Legal Representative Witness

Date: / /
Date: / /

This health care provider will abide by the terms presented within this Notice. For any uses or disclosures that are not listed below, the health care provider will obtain a written authorization from you for that use or disclosure, which you will have the right to revoke at any time, as explained in more detail below. **The health care provider reserves the right to change the health care provider's privacy practice and this Notice.** Revisions to the Notice will be posted in the health care providers and upon your request, provided to you in a paper format.