

# MORRIS PARK DENTAL

960 Morris Park Ave, Bronx, NY 10462 · [www.MorrisParkDental.com](http://www.MorrisParkDental.com) · contact@morrisparkdental.com · (718) 863-5077

Today's Date: \_\_\_\_\_ DOB: \_\_\_\_\_ Patient Social Security # \_\_\_\_\_

Patients Name \_\_\_\_\_  
(Last) (First) (Middle Initial) (Preferred)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Drivers License # \_\_\_\_\_ Male/Female Single/Married/Child Other \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

E – Mail Address: \_\_\_\_\_

**Preferred Method of Contact:** Email  Phone  Text      **Preferred Method of Mail:** Email  Paper Mail

**In Case of Emergency Contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Contact # \_\_\_\_\_

**Who may we thank for referring you?** \_\_\_\_\_

**Account Information:**

Individual Responsible for this account \_\_\_\_\_

Relationship to patient \_\_\_\_\_ (Last) (First)  
DOB: \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Group # \_\_\_\_\_

**Insurance Carrier** \_\_\_\_\_ Customer Service # \_\_\_\_\_

**Flexible Health Spending Account Information** \_\_\_\_\_

## Terms and conditions

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for costs associated with their treatment, and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. We bill Usual and Customary fees. Insurance payments are not guaranteed until received from the insurance company. If we agree to accept assignment of your insurance benefits, we will charge the contractual co-payment percentage at the time of insurance payment and make any necessary adjustments at that time. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

**We have a 48 hour cancellation policy. All broken appointments are subject to a \$50 Broken Appointment fee.  
Patients may be asked to leave our practice in cases of excessive cancellations or for neglecting to abide by our office policies.**

I hereby authorize my doctor's office to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by my doctor to make a thorough diagnosis of my dental needs. These may be used for educational purposes. I also authorize my doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with my conditions, and further authorize and consent that my doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
**Patient/Guardian Signature**

\_\_\_\_\_  
**Date**

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Physician's Name \_\_\_\_\_ Physician's Phone # \_\_\_\_\_  
Physicians Address \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

## MEDICAL

1. Are you in good health? \_\_\_\_\_  YES  NO
2. Have there been any changes to your general health within the past year? \_\_\_\_\_  YES  NO
3. Date of last physical examination? \_\_\_\_\_
4. Are you now under the care of a physician? \_\_\_\_\_  YES  NO  
If so, for what condition(s)? \_\_\_\_\_
5. Have you ever had any serious illness, operation, or hospitalization? \_\_\_\_\_  YES  NO
6. Are you taking any drugs or medication? \_\_\_\_\_  YES  NO
7. List type amount and frequency if so \_\_\_\_\_
8. Are you using any recreational drugs? \_\_\_\_\_  YES  NO
9. Are you taking any over the counter drugs? \_\_\_\_\_  YES  NO
10. Are you sensitive or allergic to any medication? \_\_\_\_\_  YES  NO  
 Penicillin  Sulfa  Codeine/other Narcotic  Aspirin  Barbiturates  Iodine  other \_\_\_\_\_
11. Do you have or have you had any of the following: (Please check known conditions)  

<input type="checkbox"/> Aids or HIV	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood Diseases _____	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Stroke
<input type="checkbox"/> Heart Ailments	<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> Tumors/Growths	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Radiation treatment	<input type="checkbox"/> Asthma/Hay Fever
<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Allergies _____	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> None of the above
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Fainting Spells/ Seizures	<input type="checkbox"/> Hepatitis, Jaundice or liver disease	
		<input type="checkbox"/> Other _____	

If you checked yes to any of the above conditions, please give a brief explanation:

- 
12. Do you use tobacco now or in the past? \_\_\_\_\_  YES  NO
  13. Do you wear a cardiac pacemaker? \_\_\_\_\_  YES  NO
  14. Have you had Heart surgery? \_\_\_\_\_  YES  NO
  15. Do you have any disease or condition or problem not listed above that you think we should know about?  
If yes, what is it? \_\_\_\_\_  YES  NO
  16. If you are female, are you pregnant or nursing?  YES  NO If so, how many months? \_\_\_\_\_

## DENTAL

1. Previous Dentist \_\_\_\_\_
2. Was your pattern of visits regular, infrequent, or sporadic (circle one)
3. Have you been having any specific problems? \_\_\_\_\_  YES  NO  
Explain \_\_\_\_\_
4. Have you ever been pre-medicated with antibiotics (i.e. Penicillin, etc.) before dental treatment? \_\_\_\_\_  YES  NO
5. Does dental treatment make you nervous? \_\_\_\_\_  YES  NO
6. Do you currently have or have ever had any of the following: (Please check all known conditions)  

<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Loosening of teeth	<input type="checkbox"/> Bleeding gums
<input type="checkbox"/> Clench your teeth	<input type="checkbox"/> Sensitive Teeth at . . . . .	<input type="checkbox"/> Night <input type="checkbox"/> Day <input type="checkbox"/> Sweet <input type="checkbox"/> Temperature
<input type="checkbox"/> Cold sores	<input type="checkbox"/> Grind your teeth at . . . . .	<input type="checkbox"/> Night <input type="checkbox"/> Day <input type="checkbox"/> Hurt <input type="checkbox"/> Lock <input type="checkbox"/> Jaw Pop
7. Have you ever had any serious trouble associated with any previous dental treatment?  YES  NO
8. Have you ever had any of the following:  Facial Injury  Oral Surgery  Orthodontics  Periodontics
9. Do you like the overall appearance of your teeth? \_\_\_\_\_  YES  NO

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## NOTICE OF PRIVACY PRACTICES (DENTAL)

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, 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.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An Example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for 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** 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 be an internal quality assessment review.

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

We may contact 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 uses and disclosures will be made only with your written authorization. You may revoke such authorization 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 authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- 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 reasonably requests to receive confidential communications of protected 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 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 to provide you with notice of our legal duties and privacy practice with respect to protect health information.

This notice is effective as of April 14th, 2003 and we are required to abide by the terms of this 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. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, retaliate against you for filing a complaint.

- For Information about HIPAA 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 – (202)619-0257 – Toll Free : 1-877-696-6775

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### Patient Consent Form

**\*You May Refuse to Sign This Acknowledgement\***

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions

***I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.***

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Patient/Guardian Signature

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Date

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## ASSIGNMENT OF BENEFIT AGREEMENT

As a courtesy to our patients, Morris Park Dental will send claims to the appropriate carrier for direct reimbursement. We **cannot guarantee** payment by your insurance carrier. We are in direct contact with the insurance carriers. With your assistance, we will attempt to maximize your insurance coverage in order to lessen your out-of-pocket expenses.

In the event that benefit coverage is un-assignable, the patient is responsible for the account balance before treatment is rendered, unless otherwise specified. Once notification is received in the mail, the patient is to forward a copy of the explanation of benefits (EOB) along with a payment in the same amount issued. If payment is not received within 30 days of the EOB, you will be billed for the full account balance.

Please be advised that procedures are billed on the day that services are rendered. The patient is ultimately responsible for their account with Morris Park Dental. Financial arrangements are available upon request. Please ask to speak with one of our financial coordinators for more information. Your signature below attests to the fact that you have been informed of and agree to the above protocol.

I understand that the responsibility of payment for dental services provided in the office for myself or my dependents is mine, due and payable at the time of services rendered unless financial arrangements have been made. I further understand that in the event of default I promise to pay legal interest on the indebtedness. In the event that full payment for charges incurred in connection with my dental care is not made, I agree to pay all costs of collection, including reasonable attorneys' fees, and interest at the rate of eighteen percent (18%) per annum. I agree to submit myself to the jurisdiction of the courts of Bronx, NY. I understand that the fee estimate listed for my dental treatment can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

## Pharmacy Information

*Attention Patients: We are updating our records and we need to have your correct pharmacy information so all of the prescriptions written for you will be sent directly to your pharmacy.*

Patients Name \_\_\_\_\_  
(Last) (First) (Middle Initial) (Preferred)

Patients Date of Birth \_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Pharmacy Phone Number \_\_\_\_\_

Pharmacy Address \_\_\_\_\_

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WWW.ISLEEPPROGRAM.COM  
Tel. 888-929-SLEEP (7533)  
Fax. 888-929-7537

## Sleep Health Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: M / F Height: \_\_\_\_\_

1. Do you snore or have been told by someone that you snore? Yes (2 pts) No
  
2. Has anyone ever noticed that you quit breathing during your sleep? Yes (3 pts) No
  
3. Do you ever awaken with a sensation of gasping or choking? Yes (3 pts) No
  
4. Do you often feel tired or fatigued immediately after getting up from sleep? Yes (1 pt) No
  
5. During your waking time, do you often feel tired, fatigued or not up to par? Yes (1 pt) No
  
6. Have you, in the past 6 months, nodded off or fallen asleep in any situation(s) where you did not intend to? Yes (1 pt) No
  
7. Do you have (or are being treated for) high blood pressure? Yes (1 pt) No

Total Points: \_\_\_\_\_

Please add up the points from questions that were answered "yes". If the point total is greater than 2, the patient is a good candidate for a diagnostic sleep study.

- 0 - 2 = Lower risk of having Obstructive Sleep Apnea
- 3 - 4 = Moderate risk of having Obstructive Sleep Apnea
- 5 - 12 = High risk of having Obstructive Sleep Apnea

*Este cuestionario utiliza porciones de los cuestionarios Berlin y Epworth, los cuales son utilizados por la AASM como herramienta diagnóstica para la Apnea Obstruktiva del Sueño (OSA).*