TrueSmiles Dental

PATIENT REGISTRATION

1719 Sheridan Drive
Tonawanda, NY 14223
Phone: (716) 424 - 0025, Fax: (716) 551- 0200

Last Name: _____ First Name: _____ Middle Initial: ___

Patient is ___ Policy Holder ___ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

Last Name: _____ First Name _____ Middle Initial:

Address _____ Address 2 _____

City _____ State ____ ZIP _____

Home Phone _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date _____ Soc Sec. # _____ Drivers Lic: _____ Issuing State ____

___ Responsible Party is also a Policy Holder for Patient ___ Primary Insurance Policy Holder ___ Secondary Insurance Policy Holder

Patient information

Address: _____ City: _____ State ____ ZIP _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic.: _____ Issuing State ____

E-mail: _____ ___ I would like to receive correspondences via e-mail.

emergency contact: _____ emergency contact #: _____

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Section 3

Medicaid ID _____

Care Credit # _____

Dentaquest _____

Healthplex _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec #: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

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MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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

Women: Are you
Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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 Problem ○ 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 _____

Comments: _____

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 _____ DATE _____

TrueSmiles Dental
1719 Sheridan Dr., Tonawanda, NY 14223
(716) 424 – 0025 (716) 551– 0025
truesmilesbuffalo@gmail.com
www.truesmilesdentalclinic.com

Consent To Use and Disclose Protected Health Information For Treatment, Payment and Health Care Operations

Section A:

Client/Individual's Name:_____
Client/Individual's ID # :_____

I authorize the use and disclosure of my Protected Health Information by the Agency listed below and by the Agency's staff and Business Associates for purposes of treatment, payment, and health care operations.

Name of Agency Using and Disclosing the Information:
TrueSmiles Dental, at 1719 Sheridan Drive, Tonawanda, NY 14223

Section B:

Important Information Regarding this Consent**:**

1. I understand New York laws require my consent before the Agency may use or disclose my Protected Health Information for treatment, payment or health care operations.

2. I understand that this information may be used or disclosed by the Agency to:

   - ☐ plan my care and treatment;
   - ☐ communicate among various health care professionals who are involved in my care or treatment;
   - ☐ obtain payment for care provided by the Agency or for the payment activities of another health care provider or entity;
   - ☐ provide information to my health insurance company or plan;
   - ☐ obtain payment from my health insurance company or plan; and
   - ☐ assess and review the quality of my care.

3. I understand that my signature on the consent is required in order for me to receive care from the Agency and that the Agency may condition my treatment on obtaining my consent for use and disclosure of my Protected Health Information for treatment, payment and health care operations.
4. I understand that further information on the Agency's uses and disclosures of my Protected Health Information for treatment, payment and health care operations is included in the Agency's Notice of Privacy Practices.

SIGNATURE

I have read and understand the terms of this consent. I have had an opportunity to ask questions about the use or disclosure of my Protected Health Information.

Signature of Client/Individual or Personal Representative:_____

Print Name of Client/Individual or Personal Representative:_____

Description of Personal Representative's Authority:_____

Date:_____

CONTACT INFORMATION

Contact information of the personal representative who signed this form:

Address:_____

_____

_____

Telephone: _____(Daytime) _____(Evening)

For Agency Use Only

For Agency Use Only.

Date Agency Obtained Consent:_____

Name and Title of Person Obtaining Consent:_____

Action Taken by Agency on Consent:_____

_____

_____

Consent for Dental Treatment Procedures and Anesthesia

Patient's Name: _____ Date of Birth: _____

1. I hereby authorize TrueSmiles Dental associates (dentists, hygienists) to perform routine dental treatment and/or anesthesia and to perform other intervention that their dental judgment dictates during said treatment.

2. I have been informed of the purpose of the treatment and the expected benefits and complications (from known and unknown causes), attendant discomforts and risk that may arise, as well as possible alternatives to the proposed treatment, including no treatment. The attendant risks of no treatment have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.

3. I understand that during the course of the treatment, unforeseen conditions may arise which necessitate intervention different from those contemplated. I, therefore, consent to the performance of additional intervention which the dentist and/or associates may consider necessary.

4. I acknowledge that no guarantees have been made to me concerning the results intended from the intervention.

5. I confirm that I have read of have had the above read to me and fully understand and that all blank spaces have been completed prior to my signing.

Patient/Alternating Legal Guardian (if patient is under 18 years of age or unable to sign):

_____ _____ _____

Signature Print Name Date

Relationship (if signed by person other than patient): _____

Dentist Certification:

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment and attendant risks), the proposed procedure(s). I have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/legal guardian fully understands what I have explained and answered.

_____ _____ _____

Signature Print Name Date

THIS FORM MUST BE SIGNED BY THE INDIVIDUAL'S LEGAL GUARDIAN

Patients' Bill of Rights for Diagnostic & Treatment Centers (Clinics)

As a patient in a Clinic in New York State, you have the right, consistent with law, to:

(1) Receive services(s) without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin or sponsor;

(2) Be treated with consideration, respect and dignity including privacy in treatment;

(3) Be informed of the services available at the center;

(4) Be informed of the provisions for off-hour emergency coverage;

(5) Be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care;

(6) Receive an itemized copy of his/her account statement, upon request;

(7) Obtain from his/her health care practitioner, or the health care practitioner's delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand;

(8) Receive from his/her physician information necessary to give informed consent prior to the start of any nonemergency procedure or treatment or both. An informed consent shall include, as a minimum, the provision of information concerning the specific procedure or treatment or both, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting the patient to make a knowledgeable decision;

(9) Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her action;

(10) Refuse to participate in experimental research;

(11) Voice grievances and recommend changes in policies and services to the center's staff, the operator and the New York State Department of Health without fear of reprisal;

(12) Express complaints about the care and services provided and to have the center investigate such complaints. The center is responsible for providing the patient or his/her designee with a written response within 30 days if requested by the patient indicating the findings of the investigation. The center is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the center response, the patient may complain to the New York State Department of Health's Office of Primary Health Systems Management;

(13) Privacy and confidentiality of all information and records pertaining to the patient's treatment;

(14) Approve or refuse the release or disclosure of the contents of his/her medical record to any health-care practitioner and/or health-care facility except as required by law or third-party payment contract;

(15) Access to his/her medical record per Section 18 of the Public Health Law, and Subpart 50-3. For additional information link to: http://www.health.ny.gov/publications/1449/section_1.htm#access

(16) Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors; and

(17) Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the center.

NEW YORK STATE | Department of Health

Patients' Rights, 10NYCRR, Section 751.9

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