DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date ______

SS/HIC/Patient ID # ______

Patient Name ______
Last Name

______
First Name Middle Initial

Address ______

E-mail ______

City ______

State ______ Zip ______

Sex ☐ M ☐ F Age ______

Birthdate ______

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______

Occupation ______

Employer/School Address ______

______

Employer/School Phone (____) ______

Spouse's Name ______

Birthdate ______

SS# ______

Spouse's Employer ______

Whom may we thank for referring you? ______

2 DENTAL INSURANCE

Who is responsible for this account? ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______

Birthdate ______ SS# ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______ and assign directly to
Name of Insurance Company(ies)

Dr. ______ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______
Signature of Patient, Parent, Guardian or Personal Representative

______
Please print name of Patient, Parent, Guardian or Personal Representative

______ ______
Date Relationship to Patient

3 PHONE NUMBERS

Home (____) ______ Work (____) ______ Ext ______ Cell Phone (____) ______

Spouse's Work (____) ______ Best time and place to reach you ______

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ______ Relationship ______

Home Phone (____) ______ Work Phone (____) ______

4 DENTAL HISTORY

Reason for today's visit ______

______

Former Dentist ______

City/State ______

Date of last dental visit ______

Date of last dental X-rays ______

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

Bad breath ☐ Yes ☐ No
Bleeding gums ☐ Yes ☐ No
Blisters on lips or mouth ☐ Yes ☐ No
Burning sensation on tongue ☐ Yes ☐ No
Chew on one side of mouth ☐ Yes ☐ No
Cigarette, pipe, or cigar smoking ☐ Yes ☐ No
Clicking or popping jaw ☐ Yes ☐ No
Dry mouth ☐ Yes ☐ No
Fingernail biting ☐ Yes ☐ No
Food collection between the teeth ☐ Yes ☐ No
Foreign objects ☐ Yes ☐ No
Grinding teeth ☐ Yes ☐ No
Gums swollen or tender ☐ Yes ☐ No
Jaw pain or tiredness ☐ Yes ☐ No
Lip or cheek biting ☐ Yes ☐ No
Loose teeth or broken fillings ☐ Yes ☐ No
Mouth breathing ☐ Yes ☐ No
Mouth pain, brushing ☐ Yes ☐ No
Orthodontic treatment ☐ Yes ☐ No
Pain around ear ☐ Yes ☐ No
Periodontal treatment ☐ Yes ☐ No
Sensitivity to cold ☐ Yes ☐ No
Sensitivity to heat ☐ Yes ☐ No
Sensitivity to sweets ☐ Yes ☐ No
Sensitivity when biting ☐ Yes ☐ No
Sores or growths in your mouth ☐ Yes ☐ No

How often do you floss? ______

How often do you brush? ______

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5 HEALTH HISTORY

Physician's Name ______________________ Date of last visit ______________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

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

Condition			Condition			Condition		
AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type ______	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
			High Blood Pressure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tonsilitis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No			
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No				Weight Loss, unexplained	☐ Yes	☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date ______________ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

____

____

Pharmacy Name ______________________________

Phone (______) ______________________________

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other ______________

☐ Latex ______________

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________________

Are you taking any new medications? ____________ If so, what? ______________________

Patient's Signature ______________________________ Date ______________

Doctor's Signature ______________________________ Date ______________

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________________

Are you taking any new medications? ____________ If so, what? ______________________

Patient's Signature ______________________________ Date ______________

Doctor's Signature ______________________________ Date ______________

*Name*____
(please print)

NRL Sensitivity Screening

1. Are you allergic to latex or rubber? ____*Yes* ____*no*

2. Have you ever had surgery? ____*Yes* ____*no*

3. Have you ever experienced any complications during surgery or a medical procedure?
requiring resuscitation? ____*Yes* ____*no*

4. Have you ever worked in an environment that brought you into constant contact with latex products? ____*Yes* ____*no*

5. Have you experienced wheezing, difficulty in breathing, coughing, rashes, swelling, hives, itching, or watery eyes when coming into contact with rubber items, such as balloons? ____*Yes* ____*no*

6. Are you allergic to bananas, avocados, chestnuts, kiwi, passion fruit, potatoes or other foods? ____*Yes* ____*no*____ *If yes, please list* ____________________

7. Do you have a history of asthma, hay fever, eczema or dermatitis? _____*Yes* ____*no*

8. Have you ever experienced swelling of the mouth or other adverse symptoms after dental procedures or with denture wear? ____*Yes* ____*no*

9. Do you frequently wear rubber gloves at home or work? ____*Yes* ____*no*

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*10. Have you ever been diagnosed with a heart murmur?*_____*Yes*_____*no*

*11. Do you require pre-medication?*______*Yes*______*no*

Signature of Patient __________________________________ *date*________________
(or parent if minor)

For Your Information

The Health Insurance Portability and Accountability Act of 1996

HIPAA is the acronym for the Health Insurance Portability and Accountability of 1996. The Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the Department of Health and Human Services to establish national standards for electronic health care transactions and nations identifiers for providers, health plans, and employers. It addresses the security and privacy of health data.

The rules protect all forms of individually identifiable health information (whether electronic, written or oral) known as Protected Health Information (PHI). PHI is defined as information that the covered entity creates or receives; relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment of fees for the provision of health care to an individual; and either identifies the individual or provides a reasonable basis to identify the individual. The rules require notifying patients about privacy rights, adopting clear privacy procedures and securing patient records.

The HIPAA Privacy Rule requires notice, consent, access and administrative requirements (generally). The Privacy Rule establishes a federal requirement that most doctors, hospitals, or other health care providers obtain a patient s written consent before using or disclosing the patient's personal health information to carry out treatment, payment, or health care operations. The Privacy Rule also provides individuals with rights to: access to information; notice; and ability to request restrictions on the uses or disclosures of health information. The Rule also sets up administrative requirements. All mechanisms are aimed at protecting the integrity, confidentiality and availability of personal health information.

The Office of Albert V. Biggiani, D.M.D., P.C. respects the confidentiality of your medical information and will protect that information in a responsible manner. We have a privacy program in place that meets the requirements of the HIPAA Privacy Regulations. We also follow all NYS privacy laws to which we are subject that do not conflict with HIPAA Privacy Regulations. However, where the NYS privacy law provides greater rights or protections than the HIPAA Privacy Regulations, we follow state law.

FOLLOWING IS A SUMMARY OF OUR PRIVACY POLICY AND PRACTICES STATEMENT. A MORE DETAILED GENERAL DESCRIPTION OF YOUR INDIVIDUAL RIGHTS, AND EXAMPLES OF THE USES AND DISCLOSURES OF INFORMATION ARE AVAILABLE UPON REQUEST.

PRIVACY POLICY AND PRACTICES STATEMENT

The Dental Office of Albert V. Biggiani, D.M.D., P.C. **(THE PRACTICE)** is committed to complying with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Regulation") and other regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, (collectively, "HIPAA") on your behalf, herein referred to as the **PATIENT**.

1. **Treatment and Services**.

   THE PRACTICE may use or disclose Protected Health Information (PHI) on behalf of, or to provide treatment and services to, the PATIENT, if such use or disclosure of PHI would not violate the Privacy Rule.

   THE PRACTICE is permitted to use and disclose Protected Health Information as long as it obtains written authorization (consent) from a patient prior to using or disclosing personal health information for purposes other than treatment, payment or health care operations.

   THE PRACTICE agrees not to use or disclose PHI other than as permitted or required by the Agreement or as Required By Law and to use appropriate safeguards to prevent use or disclosure of the PHI other than as provided by this Agreement.

   THE PRACTICE may use PHI for the proper care and treatment of the PATIENT or to carry out the appropriate care of the PATIENT.

   THE PRACTICE is permitted to disclose the PHI in its possession to third parties for the purpose of proper management and administration provided that the purpose is to provide the third party with data analyses relating to the Health Care Operations of the PATIENT (such as for dental insurance purposes).

2. **Patient Rights**

   The PATIENT'S Protected Health Information (PHI) should not be disclosed except as authorized under the HIPAA regulations.

   It is the right of the PATIENT to limit the use of his or her PHI.

   It is the right of the PATIENT to obtain access to his or her PHI.

   It is the right of the PATIENT to request communication regarding PHI by a different means or location.

   It is the right of the PATIENT to request an amendment to his or her PHI.

   It is the right of the PATIENT to request of an accounting of any non-TPO disclosures of PHI.

Albert V. Biggiani, D.M.D., P.C.
646 Commack Road
Commack, New York 11725
(631) 499-7280

Acknowledgement of Receipt of Notice of Privacy Policies
And Consent for Disclosure for Treatment, Payment and Operations

ACKNOWLEDGEMENT AND CONSENT

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the Notice.

Signature of the Patient or Personal Representative

____

Print name of Patient or Personal Representative (including description of legal authority)

____

Date

Our Financial Policy
Please Read, Sign and Return

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

This office will attempt to work within the limits of your insurance policy and help you to receive maximum benefits. However, it is important that you, the patient, understand the following:

- *It is the patient's responsibility to be familiar with the terms of his/her insurance policy.*
- *Treatment is billed to the insurance company and you are responsible for whatever they do not cover.*
- *PDO's & PPO's are fee schedules that,(if we are participating provider), we are under contractual agreement to abide by. These fee schedules provide for generous discounts from our usual fees. However ,in most cases there will still be a balance for treatment after payment from insurance.*
- *If your insurance plan includes co-payments or deductibles, these amounts must be remitted during the period of time that treatment is taking place.*
- *If there is a remaining balance, or if a treatment is not covered, fees must be paid within 30 days of billing or finance charges will accrue at a rate of 8.5% and will be added to any amount past due, as well as a $2.50 handling charge per additional statement sent after the first billing.*
- *If a payment arrangement is necessary, payments are due within the terms agreed upon. Otherwise, finance charges will accrue at a rate of 8.5%.*
- *You, the patient, are responsible for keeping track of the maximum allowances paid on your dental work.*

I understand my signature requests that payment be made by my insurance policy to the Office of Dr. Albert V. Biggiani for any services furnished to me by that dental office. I authorize the release of any of my dental information necessary to determine the benefits or the benefits payable to related services on my behalf. I also understand that I am responsible for any amount not covered by my insurance. It is my responsibility to pay reasonable attorney fees if my account is referred to an attorney for collection.

8.5% interest will be added to any amount past due

Thank you for understanding our financial policy. If you have any questions or concerns about our fees, our financial policy or your responsibility, please do not hesitate to ask.

Signature of Responsible Party**________________________________** ***date*****____________**

Our Financial Policy
Please Read, Sign and Return

Welcome To Our Office!

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

Because Dental Treatment can be costly, it is important that you, the patient, understand the following;

- ***It is not customary for this office to bill*** *for Preventive, Diagnostic and certain Restorative treatment. This includes but may not be limited to:*
    - *Examinations*
    - *X-Rays*
    - *Oral Hygiene Cleanings*
    - *Sealant and Fluoride Treatments*
    - *Fillings*

- *Office visits are payable at the time of service.*

- *Payment in full is expected upon completion of treatment requiring more than one visit.*

- *For treatments that are more costly, payment arrangements may be made, but must be paid within 30 days or within the terms agreed upon. Otherwise, finance charges will accrue at a rate of 8.5% and will be added to the amount past due, as well as a $2.50 handling charge per additional statement sent after the first billing.*

- *We accept Cash, Checks, Visa, MasterCard and American Express.*

I understand my signature represents my agreement to make payment for dental treatment in the manner consistent with the Financial Policy of the Office of Dr. Albert V. Biggiani. I also understand that I am responsible for any interest charges that might accrue if in the event I am billed for treatments rendered and my payment is past due. It is my responsibility to pay reasonable attorney fees if my account is referred to an attorney for collection.

8.5% interest will be added to any amount past due

Thank you for understanding our financial policy. If you have any questions or concerns about our fees, our financial policy or your responsibility, please do not hesitate to ask.

Signature of Responsible Party**______________________________** ***date*****____________**

Snoring, daytime sleepiness, fatigue, and/or insomnia are common in people with untreated Obstructed Sleep Apnea (OSA).

Self-evaluation can be the first step to getting diagnosed with obstructive sleep apnea (OSA).

These four yes-or-no "STOP" questions can help you determine your risk for sleep apnea:

- **S**: Do you snore loudly (loud enough to be heard through closed doors)? Y_____ N_____
- **T**: Do you often feel tired, fatigued, or sleepy during the day? Y_____ N_____
- **O**: Has anyone observed you not breathing during sleep? Y_____ N_____
- **P**: Do you have or have you been treated for high blood pressure? Y_____ N_____

The questionnaire has an even higher predictive value when you answer four more questions:

- **B**: Is your Body Mass Index or Weight more than it should be? Y_____ N_____
- **A**: Is your age more than 50 years old? Y_____ N_____
- **N**: Is your neck circumference greater than 15 ¾ inches? Y_____ N_____
- **G**: Is your gender male? Y_____ N_____

You have a high risk of sleep apnea if you answered "yes" to three or more of the eight STOP-BANG questions.

Speak to the doctor for more information.