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

Phone (____) _____ Work (____) _____ Ext ____ Cell (____) _____

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

5 HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

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:

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

---

*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.

CHDG Appointment Rescheduling/Cancellation Policy:

Understanding Appointment Rescheduling/Cancellations: In order to be respectful of other patient's needs, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be given to someone who is in urgent need of treatment. Any appointment(s) not rescheduled/cancelled 48 hours in-advance is subject to a $50 cancellation fee.

No Show Policy: A no show is an appointment that was not rescheduled or canceled in-advance. No shows inconvenience other patients who are in need of dental care and slow down the progression of treatment. A no show for a scheduled appointment is subject to a $75 cancellation fee.

CHDG is proud of the quality of patient care we provide. CHDG goes to great lengths to provide courtesy reminders for appointments. We don't want you to forget about your appointment, but once you've scheduled with us, the responsibility is still yours to keep the appointment or reschedule within the allotted time frame.

We appreciate your understanding as our number one priority is preventing and treating dental disease in the most timely and economical manner for our patients.

Please sign below affirming you have read and understand the CHDG appointment rescheduling/cancellation policy:

*Signature of Patient*_____ *Date*_____
(or parent if minor)

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.