Paul Albora, D.D.S. / Christine Valestrand, D.M.D.
100 South Jersey Avenue, East Setauket, New York 11733
631.689.5555 • www.prosthocare.com • info@prosthocare.com

PATIENT INFORMATION

Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. _____ ☐ Male ☐ Female

☐ Single ☐ Married Birthdate: _____ Social Security #: _____

Home address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Mobile phone: _____ Email: _____

Employer: _____ Business phone: _____

Business address: _____ City: _____ State: _____ Zip: _____

Whom may we thank for referring you to our office? _____

Where do you prefer to be contacted? ☐ Home ☐ Cellular ☐ Business ☐ Email

DENTAL INSURANCE INFORMATION

Name of insured person: _____ Relationship to patient: _____

Employer: _____ Business phone: _____

Business address: _____ City: _____ State: _____ Zip: _____

Insurance Co. name: _____ Phone: _____ Group #: _____

ADDITIONAL DENTAL INSURANCE INFORMATION

Name of insured person: _____ Relationship to patient: _____

Employer: _____ Business phone: _____

Business address: _____ City: _____ State: _____ Zip: _____

Insurance Co. name: _____ Phone: _____ Group #: _____

RESPONSIBLE PARTY

Name of person responsible for payment: _____ Relationship to patient: _____

If the person responsible for payment is someone other than the patient, please complete the section below so that we have the appropriate billing information for your account.

Is the person responsible for payment currently a patient in our office? Yes ❑ No ❑

Home address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Mobile phone: _____ Email: _____

Employer: _____ Business phone: _____

Business address: _____ City: _____ State: _____ Zip: _____

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HEALTH HISTORY

Patient name: _____ Birthdate: _____

Physician name: _____ Physician phone: _____

Do you take any medications?

Yes ❑ **No** ❑ If yes, please list all medications and the reason why you are taking them.

_____

_____

Do you smoke cigarettes or use smokeless tobacco? Yes ❑ **No** ❑

Have you ever taken oral or intravenous bisphosphonate drugs for osteoporosis, metastatic cancer, or other conditions?
Examples of bisphosphonates are alendronate (Fosamax®), risedronate (Actonel®), pamidronate (Aredia®) and zoledronate (Zometa®).

Yes ❑ **No** ❑

Are you allergic to any of the following?

Yes	No		Yes	No		Yes	No	
❑	❑	Penicillin	❑	❑	Sulfa drugs	❑	❑	Other allergies (If yes, please explain)
❑	❑	Local anesthetics	❑	❑	Latex			_____

Do you have, or have you ever had, any of the following?

Yes	No		Yes	No	
❑	❑	Alcohol or drug addiction	❑	❑	High blood pressure
❑	❑	Anemia	❑	❑	HIV or AIDS
❑	❑	Artificial joint replacement (hip, knee, etc.)	❑	❑	Kidney problems
❑	❑	Artificial heart valve	❑	❑	Liver problems
❑	❑	Asthma	❑	❑	Lung problems
❑	❑	Cancer	❑	❑	Psychiatric care
❑	❑	Congenital heart defect	❑	❑	Respiratory problems
❑	❑	Corticosteroid treatment	❑	❑	Radiation treatment
❑	❑	Dental phobia or anxiety	❑	❑	Rheumatic fever
❑	❑	Diabetes	❑	❑	Sinus problems
❑	❑	Epilepsy or seizures	❑	❑	Stomach or intestinal problems
❑	❑	Excessive bleeding	❑	❑	Stroke
❑	❑	Fainting spells or dizziness	❑	❑	Thyroid problems
❑	❑	Heart murmur	❑	❑	Tuberculosis
❑	❑	Heart pacemaker	❑	❑	Tumors or growths
❑	❑	Heart attack or heart problems	❑	❑	Other health problems
❑	❑	Hepatitis	❑	❑	If female, are you pregnant?
❑	❑	Herpes or cold sores	❑	❑	If female, do you take birth control pills?

Please provide additional information for all "yes" responses:

_____

_____

Signature: _____ Date: _____

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DENTAL HISTORY

Patient name: _____

What is the reason for your dental visit today? _____

_____

Do you currently have any teeth that are sensitive?

Yes ❑ **No** ❑ If yes, please explain. _____

_____

_____

When was the last time you saw a dentist? _____

When was your last professional cleaning? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

	Yes	**No**
Have you ever been treated for periodontal disease (gum disease)?	❑	❑
Do you feel that you can chew well with your teeth?	❑	❑
Do you grind or clench your teeth?	❑	❑
Do you ever have jaw pain or jaw muscle soreness?	❑	❑
Have you ever worn a nightguard or been told that you should?	❑	❑
Do you like the way your smile looks?	❑	❑
Do you like the color of your teeth?	❑	❑
Do you have any teeth or restorations that you are unhappy with?	❑	❑
Would you like to discuss esthetic improvements that can be made to your smile?	❑	❑

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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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") 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. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA," 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 healthcare operations.

- **Treatment** means providing, coordinating or managing healthcare and related services by one or more healthcare 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.
- **Healthcare 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 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 action relying on your authorization.

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Notice of Privacy Practices *(continued)*

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

- The right to request restrictions on certain uses and disclosures of protected heath 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 reasonable 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 receive an accounting of disclosures of 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 and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the 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, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information.

For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independent Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll free: 1-877-696-6775

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Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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 certification.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 healthcare 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.

Patient name: _____

Signature: _____

Date: _____