DR. RABINOWITZ WELCOMES YOU TO OUR OFFICE!

I understand the information on both sides of this form is necessary to provide me with dental care in a safe manner.

PATIENT INFORMATION

LAST _____ PREFERRED NAME _____

FIRST _____ MIDDLE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (____) _____ WORK PHONE (____) _____

EMAIL _____ CELL PHONE (____) _____

SOCIAL SEC.# _____ SEX M F MARITAL STATUS S M D W

BIRTH DATE _____ EMPLOYED BY _____

EMPLOYERS ADD _____ CITY _____

FULL TIME STUDENT? Y N IF YES, SCHOOL _____ CITY _____

ZIP _____ REFERRED BY _____

DENTAL HISTORY

PREVIOUS DENTIST _____ ADDRESS _____ PHONE (____) _____

HOW LONG SINCE YOUR LAST DENTAL VISIT? _____ WHAT WAS DONE THEN? _____

HOW LONG SINCE: YOUR TEETH WERE LAST CLEANED? _____ LAST FULL SET OF X-RAYS? _____

HOW OFTEN DO YOU: HAVE YOUR TEETH CLEANED? _____ BRUSH YOUR TEETH? _____

HAVE ANY OF THE FOLLOWING CONDITIONS EVER BEEN PERTINENT TO YOUR MEDICAL OR DENTAL HISTORY?

BLEEDING GUMS ..... Y N	PAIN OR RINGING IN EARS ..... Y N	BURNING TONGUE ..... Y N
TENDER OR SWOLLEN GUMS ..... Y N	TIRED JAWS ..... Y N	SINUS CONDITION ..... Y N
LOOSE TEETH ..... Y N	DO YOU CLENCH YOUR TEETH ... Y N	HAVE YOU HAD:
SENSITIVE TEETH ..... Y N	COMPLICATED EXTRACTION ..... Y N	Orthodontics (braces) ..... Y N
MISSING TEETH NOT REPLACED. Y N	UNUSUAL DENTAL EXPERIENCES Y N	Periodontal (gum) Tx ..... Y N
PAINFUL OR SORE AREAS ..... Y N	THUMB OR FINGER SUCKING ..... Y N	Crown (cap) or Bridges ..... Y N

CHIEF COMPLAINT _____ ROOT CANAL (ENDODONTICS) ..... Y N

ARE YOU HAPPY WITH YOUR SMILE? _____

CAN YOU CHEW ON BOTH SIDES? _____

ARE THERE ANY FOODS YOU CAN'T EAT? _____

IF YOU COULD CHANGE ANYTHING ABOUT YOUR DENTAL HEALTH WHAT WOULD IT BE? _____

_____

REMARKS _____

_____

_____

MEDICAL HISTORY

Have any of the following conditions ever been pertinent to your medical history?

Cancer ..... Y N	High Blood Pressure ..... Y N	Tuberculosis ..... Y N	Bladder Trouble ..... Y N
Radiation Therapy ..... Y N	Low Blood Pressure ..... Y N	Multiple Sclerosis ..... Y N	Epilepsy ..... Y N
Heart Trouble ..... Y N	Blood Transfusions ..... Y N	Thyroid Condition ..... Y N	Hepatitis ..... Y N
Rheumatic Fever ..... Y N	Ulcer ..... Y N	Hay Fever ..... Y N	HIV ..... Y N
Heart Murmur ..... Y N	Emphysema ..... Y N	Asthma ..... Y N	AIDS ..... Y N
Artificial Valve ..... Y N	Diabetes ..... Y N	Kidney Trouble ..... Y N	Venereal Disease ..... Y N
Artificial Joints ..... Y N	Anemia ..... Y N	Latex Allergy ..... Y N	Fen-Phen ..... Y N

ARE YOU PREGNANT? ..... Y N

HAVE YOU EVER BEEN TOLD NOT TO TAKE NOVOCAINE? ..... Y N

DO YOU HAVE A COLD? ..... Y N

ARE YOU PRESENTLY UNDER THE CARE OF A PSYCHIATRIST? ..... Y N

ARE YOU PRESENTLY OR HAVE YOU EVER TAKEN STEROIDS? ..... Y N

EVER HAD ABNORMAL BLEEDING FROM EXTRACTION OF TEETH OR CUTS? ..... Y N

ARE YOU ALLERGIC TO ANY PARTICULAR MEDICINE OR DRUGS? ..... Y N

IF SO, WHICH MEDICINES OR DRUGS? _____

LIST ALL DRUGS OR MEDICATIONS YOU ARE PRESENTLY TAKING OR HAVE TAKEN IN THE PAST 12 MONTHS.

_____

IN CASE OF EMERGENCY NOTIFY _____ PHONE (____) _____ RELATION _____

PHYSICIAN _____ PHONE (____) _____ LAST EXAM _____

RESPONSIBLE PARTY

LAST _____ TITLE _____

FIRST _____ MIDDLE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (____) _____ BIRTH DATE _____

WORK PHONE (____) _____ SEX M F SOCIAL SEC. # _____

NUMBER OF CHILDREN _____ DRIVERS LICENSE # _____ STATE _____

Preferred method of payment CASH CHECK CREDIT CARD

Nearest friend or relative NOT living in same household:

Name _____ Phone (____) _____

INSURANCE

PRIMARY DENTAL INSURANCE:

EMPLOYER'S NAME _____ PHONE (____) _____

ADDRESS _____ CITY _____ St. _____ ZIP _____

EMPLOYEE'S NAME _____ RELATION TO PATIENT _____

GROUP # _____ EMPLOYEE # _____ SOCIAL SECURITY # _____ DOB _____

INSURANCE COMPANY NAME _____

ADDRESS _____ CITY _____ St. _____ ZIP _____

PHONE # (____) _____

CONSENT

I have answered all questions honestly and to the best of my knowledge. If further information is needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication. I authorize the doctor or his staff to take any necessary x-rays, models, photos, and other diagnostic aids needed to make a thorough diagnosis of the patient's dental needs. I authorize the doctor and staff to perform and administer treatment, medication, and therapy that may be indicated.

AGREEMENT TO PAY

Payment for dental services provided in this office for myself and my dependents are due and payable at the time services are rendered unless financial arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a billing charge may be added to my account. If an account must be turned over to a collection agency the fee charged by that agency will be added to my account.

Signature _____ Date _____

(Patient or Parent / Guardian if Minor)

Fred M Rabinowitz DDS PA

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient/Guardian of Patient

_____ _____

Legal Representative/Guardian Relationship of Legal Representative/Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ☐
I could not communicate with the patient ☐
The patient refused to sign ☐
The patient was unable to sign because ☐
Other (please describe) ☐

_____
Signature of Privacy Officer