Chilmark Dental P.C.

15 Pleasantville Rd.
Ossining, NY 10562

Phone: (914) 941-2200

Welcome We are pleased you have selected us to provide dental care for you and your family

Patient Information (CONFIDENTIAL)

Email _____ Patient # _____

Cell # _____ Soc. Sec # _____

Today's Date _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

If Patient is a Student, Name of School / College _____ City _____ State _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency 1) _____ Phone _____

2) _____ Phone _____

3) _____ Phone _____

Responsible Party

Relationship

Name of Person Responsible for this Account _____ to Patient _____

Address _____ Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information

Relationship

Name of Insured _____ to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Insurance ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much Is Your Deductible? _____ How Much Have You Used? _____ Max Annual Benefit _____

DO YOU HAVE ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Insurance ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much Is Your Deductible? _____ How Much Have You Used? _____ Max Annual Benefit _____

PLEASE COMPLETE OTHER SIDE OF FORM

Patient Medical History

Chilmark Dental,
PC 15 Pleasantville
Road Ossining, NY
10562

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Do you use tobacco?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Are you wearing contact lenses?	☐	☐

Date of last TB test _____

7. Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. Women Only:	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergics	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Other	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Cough with Blood	☐	☐
Persistant Cough	☐	☐	Mitral Valve Prolapse	☐	☐	Herpes	☐	☐
						Blood Disorders	☐	☐

Patient Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you had any orthodontic work?	☐	☐
13. Have you ever had any prolonged bleeding following extractions?	☐	☐
14. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15. Have you ever had instructions on the care of your gums?	☐	☐

Authorization and Release

There is a $25.00 Fee for missed appointments

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____

Signature of patient or parent if minor

Doctor's Comments _____

_____

_____ Signature _____ Date _____

CHILMARK DENTAL P.C.

Payment & Financial Agreement

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. In order to achieve these goals, we need your assistance and understanding of our payment and financial policy. We offer the following methods of payment:

- **Payment in full** is due at the time of service. Cash, Check, Debit Card, MasterCard, and Visa are accepted.
- For patients with insurance, we will accept payment directly from the insurance company, if it is assignable. We require that the deductible and non-covered fees be paid at each visit. We will do our best to calculate these fees prior to you leaving our office. Until we receive the explanation of benefits from your insurance company, we do not know the actual fees and additional fees may be due. You will receive a statement from our office stating the amount outstanding.
- We collaborate with Lending Tree for a financing option. Applications may be completed online at www.lendingtree.com. If approved, print off approval with our account number and bring to your appointment.
- Any parent/guardian bringing a child to our office is legally responsible for payment of all services rendered. We do not bill individual parents for the child's co–payment.
- We offer an In-House Dental Discount Plan to patients without insurance. If you are interested in more information, please contact the front desk.
- For your convenience, we provide patients with the option to authorize the use of their credit card. These authorizations allow Chilmark Dental P.C. to charge a patient's credit card for unpaid copays or account balances in our office without your presence but only after your consent.

Important Information Regarding Your Dental Benefits

- Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. This office files your insurance as a courtesy to you.
- Not all dental services are a covered benefit in all contracts. It is your responsibility to know your benefits.
- **You** (not the insurance company) are responsible to us for all our fees for services rendered to you.
- An **ESTIMATE** will be given of the benefits that the insurance company is expected to pay. Remember that this is only an **ESTIMATE** and that the actual cost may vary.
- **BROKEN/MISSED APPOINTMENT:** Appointments reserve a specific time with the dentist or hygienist to perform and provide the care you need. These scheduled times are planned for your convenience and hold great value. We require 24-hour notice of canceling or rescheduling your appointment, if 24 hours' notice is not given a $45.00 fee will be charged.

I acknowledge I have received and agreed to Chilmark Dental P.C.'s Payment & Financial Policies. Patient or Responsible Party:

_____ _____

Signature **Date**

Credit Card Authorization

I authorize Etta J. Lobel, D.M.D. of Chilmark Dental P.C. to charge my credit card as follows:
Select your preferred type of authorization:

☐ **Continuous Authorization:** Chilmark Dental P.C. will keep this information securely on file to cover any unpaid account balances, (Patients will be notified prior to credit card being charged).

☐ **One Time Authorization:** Chilmark Dental P.C. will use this information **ONCE** to cover any unpaid balances after payment from insurance for treatment dated _____ through _____

☐ **Broken/Missed Appointment:** Chilmark Dental P.C. will use this information in the event of broken, missed, or rescheduled appointments without adequate notice to cover the $45.00 fee. Patients will be notified prior to credit card being charged.

☐ **Mutually Agreed Upon Payment Plan:** If patients require financial arrangements in the form of a payment plan to cover the cost of treatment, Chilmark Dental P.C. will arrange automatic monthly credit card charges per your request. (Agreed upon amounts may vary based on the cost of treatment. Payment plans shall not apply to Preventive and/or Basic procedures)

Please charge $_____on or after the _____of each month for:

☐ 01 Month ☐ 02 Months ☐ 03 Months

(Final charge may also cover any unpaid balance on the account, which may be a greater amount than the amount listed above.)

☐ **Decline:** I do not wish Chilmark Dental P.C. to keep my Credit Card on file.

Credit Card Information:

Credit Card: ☐ Visa ☐ MasterCard

Card #: _____

Expiration Date:_____/_____CVV Code: _____

Cardholder Signature _____ Printed Name _____

Billing Street Address/Zip Code: _____

_____

We will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program. We appreciate the opportunity to serve you and thank you for being an important part of our Chilmark Dental P.C. Family.

Patient or Responsible Party: _____ Date: _____

Chilmark Dental P.C.

15 Pleasantville Rd.
Ossining, NY 10562

Phone: (914) 941-2200

Authorization for Signature on File

Release of Information/Financial Responsibility/Authorization for Payment

I, _____ and/or _____
Name of Patient (Parent or Guardian if Minor) Name of Insured

hereby authorize the office of Chilmark Dental P.C. to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with _____. I hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed above. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and material not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the claim

This "Authorization" will be valid from this date forward and shall expire if my employment with the above company terminates.

A photocopy of this document may act as an original.

_____ _____
Signature of Insured Witnessed by

_____ Today's Date _____
Signature of Patient (Parent or Guardian if Minor

Chilmark Dental, P.C.

15 PLEASANTVILLE ROAD
OSSINING, NY 10562

(914) 941 -2200

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (print) _____ have received a copy of this office's Notice of Privacy Practices.

_____ _____
Signature Date

CHILMARK DENTAL, P.C.

15 PLEASANTVILLE
ROAD OSSINING, NY 10562

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information tha t we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:
Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;

- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provid e copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may—but are not required to—prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for more information about fees.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.
If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Provider Contact Office: Dr. Etta J. Lobel - Chilmark Dental P.C.

Telephone: (914) 941-2200 Fax: (914) 941-5174

E-Mail: elseale2@aol

Address: 15 Pleasantville Road Ossining, NY 10562