HAMPTON SMILE DENTAL, P.L.L.C. - ROBERT J. SICURELLI, JR.

**Patient Name**_____ **Birth date** _____

## DENTAL HISTORY

What is the reason for today's visit? _____

When was your last visit to a dentist? _____

Have past dental experiences been satisfactory? _____

How do you feel about the appearance of your teeth? _____

Do you have or have you had any of the following? (Please check all that apply to you)

- o Bleeding gums
- o Broken fillings
- o Chronic bad breath
- o Decayed teeth
- o Food catches between teeth
- o Grinding or clenching of teeth
- o Injury to teeth or jaw
- o Loose teeth
- o Orthodontic treatment
- o Periodontal treatment
- o Painful or locking jaw
- o Sensitivity to sweet, hot, cold, biting
- o Sores, growths or swelling in mouth

## MEDICAL HISTORY

Do you have or have you had any of the following? (Please check all that apply to you)

- o Anemia
- o Arthritis, rheumatism
- o Artificial heart valves
- o Artificial joints
- o Asthma, sinus problems
- o Autoimmune disease
- o Back problems
- o Blood disease
- o Abnormal bleeding, prolonged healing, bruising easily
- o Cancer
- o Chemical dependency
- o Chemotherapy
- o Circulatory problems
- o Cortisone treatments/steroids
- o Cough, persistent/chronic
- o Cough up blood
- o Diabetes
- o Epilepsy/seizures
- o Fainting
- o Glaucoma/eye disorders
- o Headaches, migraine headaches
- o Heart murmur
- o Heart disease (describe)
- o Hemophilia
- o Hepatitis/liver diseases/jaundice
- o High blood pressure
- o Low blood pressure
- o HIV positive
- o AIDS
- o Kidney disease
- o Mitral value prolapse
- o Malignancy or tumor/cyst
- o Nervous disorders
- o Pacemaker
- o Psychiatric care
- o Radiation treatment
- o Respiratory disease
- o Rheumatic fever/rheumatic heart disease
- o Shortness of breath
- o Skin rash
- o Stroke
- o Congestive heart failure
- o Thyroid disease
- o Tobacco habit
- o Tuberculosis
- o Ulcer/digestive disorders
- o Venereal disease

Physician_____ Tel #_____

Date of last physical exam:_____

Please list all medications you are currently taking as well as over-the-counter medications, herbal remedies, vitamins, homeopathic remedies: _____

_____

Allergies/reactions to medications, or other allergies? _____

(Women) Are you pregnant? _____ Nursing?_____ Taking birth control pills?_____

Are you presently under a physician's care? _____Explain_____

Do you consider yourself to be in good health?_____

Please describe any impending operations, recent injuries or other information the dentist should be aware of:

_____

Patient signature_____Date_____ Dentist's initials_____

PATIENT NAME_____ TODAY'S DATE_____

HOME ADDRESS_____ DATE OF BIRTH_____

MAILING ADDRESS_____ HOME PHONE _____

_____

EMAIL _____ CELL PHONE _____

EMPLOYER_____ BUSINESS PHONE_____

REFERRED BY_____ SS#/SIN_____

## PATIENT CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change it *Notice of Privacy Practices* from time to time and that I may contact this organization at any time 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 discussed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Please provide the name(s) of person(s) you would allow Dr. Sicurelli to discuss your dental treatment with:_____

Patient Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

# Hampton Smile Dental, P.L.L.C.
## Patient Communication Consent Form
### How would you like us to communicate with you?

Our dental office sends appointment reminders, information about treatment, payment and other communications. Please tell us how you would like us to communicate with you.

**Your name:**_____ **Today's Date**_____

| **Method** | **Number/Address** | **Messages (Yes or No)** |
|---|---|---|
| __Home Phone | (____)_____ | ☐ Yes ☐ No |
| __Cell Phone | (____)_____ | ☐ Yes ☐ No |
| __Work Phone | (____)_____ | ☐ Yes ☐ No |
| __Alternate Phone | (____)_____ | ☐ Yes ☐ No |
| __Text Messages | (____)_____ | ☐ Yes ☐ No |
| __E-Mail | _____@_____ | ☐ Yes ☐ No |
| __Postal Mail | _____ | ☐ Yes ☐ No |

I authorize Hampton Smile Dental PLLC to discuss my healthcare information (which may include history, diagnosis, treatment, and other health information) with the contacts listed below. I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not my information released to anyone else.

| **NAME** | **RELATONSHIP TO PATIENT** | **CONTACT INFORMATION** |
|---|---|---|
| | | |
| | | |

**EMERGENCY CONTACT ONLY**

NAME_____ Phone_____

By my signature below I acknowledge that I have read and understand the guidelines to patient communication and information provided on this consent form.

**Patient name printed**_____

**Patient/Authorized signature** _____ **Date**_____

**Hampton Smile Dental P.L.L.C.**
**157 Wickapogue Road**
**Southampton, New York, 11968**

## AUTHORIZATION AND CONSENT TO SEND UNENCRYPTED PATIENT INFORMATION BY EMAIL AND OTHER ELECTRONIC MEANS

Until I tell you in writing to stop, I authorize **Hampton Smile Dental PLLC** to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or **Hampton Smile Dental PLLC** health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

**I understand that:**

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I do not sign this form, **Hampton Smile Dental PLLC** may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be disclosed and no longer protected by privacy law.
- **Hampton Smile Dental PLLC** does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop e-mailing my patient information at any time, but if I do so, this will not affect emails that **Hampton Smile Dental PLLC** already sent before receiving my written instructions to stop.

**Patient name (please print)** _____

**Signature:**_____ **Date:** _____

**Dental Team: Give a copy of this signed form to the patient. Save the original in the patient's file.**

# NOTICE OF PRIVACY PRACTICES

(MEDICAL)

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 ("HIPAA") 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. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", 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 health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **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.
- **Health care 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 uses and 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 actions relying on your authorization.

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

- The right to request restrictions on certain uses and disclosures of protected health 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.

**Patient Copy**

ITEM 070-6069 25946 © MAY 2002

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 1, 2017 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 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 HIPAA
or to file a complaint:

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