PATIENT REGISTRATION

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip:

Home Phone: Work Phone: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Pref. Dentist: J.G. Stein

Pref. Pharmacy:

Pref. Hyg:

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

J. G. Stein General Dentistry

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date: _____

J. G. Stein General Dentistry PLLC

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716-372-8440
www.jgsteindentistry.com
jgsteinoffice@gmail.com

OFFICE POLICIES

Welcome and thank you for selecting us as your personal dental care team. To promote a long-term and mutually satisfying relationship, we would like to explain our office policies. Please read this carefully and let us know if you have any questions or concerns before treatment is rendered. Submission to treatment indicates that you consent to and agree with the terms of our policies as explained in this document.

Below, please initial on each line at the beginning of each paragraph and sign and date on the last page

TREATMENT

__You will find our entire office staff is dedicated to helping you improve your dental health as efficiently as possible. Every effort will be made to make your visit comfortable and pleasant. Our goal to provide you with the best dentistry available and your diagnosis will be based upon your individual needs. We assume you are just as concerned as we are about maintaining good oral health ... therefore, it is important that we do not allow dental insurance to be a determining factor in what treatment will be necessary to maintain your proper dental health. Example: We use only the best BPA-free resin (tooth colored) filling material and do not use amalgam (silver) due to its mercury content, We advise you to call your insurance company to obtain their policy on resin fillings. Please feel free to discuss your treatment with the doctor at any time.

INSURANCE

__Your insurance may not cover your services or may only partially cover them. Any estimate given by this office is considered a guideline; we make no guarantee of what your insurance company will actually pay. We will electronically file your primary dental

insurance for you. Be aware that we are **out of network** with all insurance companies so calling your insurance to get the information of what your insurance will pay is the patient's responsibility. If your insurance pays you directly you're in full balance is required at each visit. Your coverage is an agreement between you and your insurance carrier; it is your responsibility to be informed of your dental benefits and eligibility and to inform us of dental insurance changes. The patient is still fully responsible for any balance for treatments rendered after your insurance pays.

APPOINTMENTS

__The time you choose for your appointment is reserved especially for you. We do not double book. To ensure you receive the best standard of care and treatment, our staff prepares for your appointment by sterilizing, organizing and arranging the setup of items prior to your arrival. In order to provide all of our patients with the same high standard of care, we require a minimum of 24 hours' notice for cancellations and reschedules. This will afford us adequate time to notify patients who are in need and on a waiting list for the first available appointment. If you No show to your appointment or do not provide a minimum of 24 hours' notice to cancel or reschedule, a fee of **$50.00** will be charged. The second missed appointment will be charged a fee of **$50.00.** The third no show you may be discharged from the practice. No future appointments or record transfer requests will be scheduled or honored until your total fees are paid. If you are **15** minutes or later for your appointment, it will be considered a no show and you will incur the **$50.00** fee and will have to be rescheduled, this is to keep all patients on schedule as much as possible.

PAYMENT

__Full payment of your charges or copay is expected at time of visit. We accept cash, personal checks, MasterCard, Visa, Discover and American Express. Payment

arrangements may be made for patients needing extensive dental work; payment arrangements must be approved and in writing before services are rendered.

RETURNED CHECKS

__Returned checks will incur a **$30** fee and will have to be paid in full before future appointments will be made.

OVERDUE BALANCES

__All balances over **90 days** will be turned over for collection unless arrangements have been made in writing beforehand with office

CONSENT and AUTHORIZE

__I certify under penalty of perjury that I am here on my own accord to obtain dental services for myself or my dependents; I do not represent any other entity or third party. I hereby authorize and assign to J.G. Stein General Dentistry directly, 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 and staff may use my health care information and may disclose such information to any of my insurance companies 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 it is revoked in writing or two years from the date signed below. I have received or reviewed the privacy practices of J. G. Stein General Dentistry, understand all information contained within this agreement and agree to the written policies in effect.

Printed Name

_____

Signature

_____

Date

_____

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: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices that are described in this notice while it is effect. This notice takes effect January 1, 2022, and will remain in effect until we replace it. We reserve the right to change our privacy practices and terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our practice sand the new terms of out Notice effective for all health information that we maintain, including health information we created or received before we make the changes, before we make significant change in our privacy practices, we will change this notice and make the new notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION: We use and disclose health information about you for treatment, payment, and healthcare operations. For Example:

TREATMENT: We may use and disclose your health information to a dentist or other healthcare provider providing treatment to you. PAYMENT: we may use and disclose your health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORAZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or 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 use or disclosures permitted by your authorization while in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason expect those described in this notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in patient's rights section of this notice, We may disclose your health information to a family member, friend or other person to extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another responsible for your care, of your location, your general condition, or death. If are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also 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 x-rays or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to you or sagely or the health or safety of others.

NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces Personnel under certain circumstances. We may disclose to authorize federal officials health information required for law enforcement counter intelligence and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: we may use or disclose your health information to provide you with appointment reminders (such as voicemail message, post cards, or letters).

PATIENTS RIGHTS

You have the right to look at or get a copy of your healthcare information, with limited exceptions. You may request that we provide 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 obtain a form sending us a litter to the address at the end of this notice.

If you request an alternative format, we will charge a cost-based fee for providing your health information in that format; contact us using the information listed at the end of this notice full explanation of our fee structure.

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclose your health information for purposes, other than treatment, payment, healthcare operations and 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.

RESTRICTION: You have the right to request that we place additional restrictions on or disclosure of your health information. We are not required to agree to these additional restrictions, but if we abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATIONS: You have the right to request that we communicate with you about your health information by alternative means or alternative locations. You must make requests in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you requested.

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

QUESTIONS AND COMPLAINTS: If you want more information about privacy practices or has any questions or concerns, please contact us:

If you are concerned that we may have violated your rights, or disagree with decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or alternative locations, you may complain to us using contact information listed at the end of this notice, You also may submit a written complaint to the U.S. Department of Health and Human Services

We support your rights to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

J.G. Stein General Dentistry
1715 W. State Street
Olean, NY 14760
JGSteinoffice@gmail.com
716-372-8440

HIPAA Authorization

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment including direct or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers (ex. your insurance company).
- Day to day operations of the practice.

I have also been informed of and given the right to review and secure a copy of Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I authorize the following person/people to receive and/or discuss my dental treatment, finances, appointments or current health status:

Name _____ Relationship_____

Name_____ Relationship_____

Name _____ Relationship_____

Print Name _____Date_____

Signature_____