Broadway Cosmetic Dentistry PC
All the care your smile will ever need

128 SOUTH BROADWAY
TARRYTOWN, NY 10591

WELCOME

Our team believes that patients treated by our office are the most important people in the world. We are delighted that you have chosen to join our family. The enjoyment we experience in our association with our patients comes from a mutual understanding of the joint responsibility regarding complete care. We believe that sharing our thoughts with our patients helps form the bond that leads to a long-lasting relationship. A bright and healthy smile is, without question, the most convincing form of communication.

Patient Information

Patient's Full Legal Name: _____

Date of Birth: _____ SSN: _____ Gender: ☐ MALE ☐ FEMALE ☐ OTHER: _____

Address: _____

City: _____ State: _____ Zip Code _____

E-mail: _____ Cell Phone: _____ Home Phone: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for ____ years

Spouse's/Significant Other's Name: _____

Patient Employer/School: _____

Occupation: _____

Employer/ School Address: _____ Employer/School Phone: _____

Whom may we thank for referring you? _____

How do you want to be addressed when called from the Reception Area? _____

I Authorize Contact from This Office to Confirm My Appointments, Treatment, And Billing:

☐ Cell Phone Confirmation	☐ Text Message to my Cell Phone
☐ Home Phone Confirmation	☐ Email Confirmation
☐ All of the Above	

HIPAA Policy

Notice of Privacy Practices: Use and Disclosure of Health Information Protected under HIPAA Effective May 1, 2014.

This document provides a summary of how health care information about you may be used and disclosed and how you can obtain access to this information. We understand that Information about you and your health is personal. We are committed to protecting your health information. It is our policy that the privacy of your Protected Health Information (PHI) not be compromised while still allowing necessary access to assure that the health care you receive is appropriate and of the highest possible quality. We pledge to you that we will protect the confidentiality of information provided to us. Your information will be used in the following manner, known as Treatment, Payment, and Healthcare Operations (TPO):

1. To provide dental treatment and/or services
2. To facilitate payment by third-party payers, when appropriate, for health care treatment you receive.
3. To facilitate the mechanisms which allow the operation of our facility. In every use of your information, we will be responsible custodians of your PHI and adhere to the standards set forth in the legislation, which created these privacy practices.

We recognize that all patients have the right to privacy in matters relating to their health, and we will not use your PHI for uses other than TPO related to health care without your conveyed permission.
You have the following rights regarding the medical information we maintain about you:

1. Access, upon request, to information that may be used to make decisions about your care.
2. To request restrictions or limitations on the PHI we disclose about you for treatment, payment or health operations. While we are not required to agree to your request, if we do agree, we will comply with the restrictions unless the information is needed to provide emergency treatment.
3. To request that we amend the PHI we maintain about you if you believe that the information we have about you is incorrect or incomplete.
4. To request an accounting of disclosures we have made for uses other than our own.
5. To request confidential communications; i.e., that we communicate with you in a certain manner or at a certain location.
6. To receive a paper copy of this notice.

All members of our staff are committed to adhering to the conditions set forth in this notice of privacy practices. Any violation will be grounds for disciplinary action. We reserve the right to change this policy in the future; such changes will be available to all patients.

Authorized Disclosures: Broadway Cosmetic Dentistry will not use or disclose your PHI without your prior authorization. You can later revoke that authorization in writing to allow any future use and disclosure. The authorization will be obtained from you by Broadway Cosmetic Dentistry. Broadway Cosmetic Dentistry may disclose Information regarding my treatment and financials to the following person(s):

_____

Patient Acknowledgment:

I acknowledge receipt of this information regarding my right to PHI privacy.

Signature (Patient, Parent, or Guardian) / Relationship to patient Date: No Expiration Until Required by Law

_____ _____

DENTAL RECORDS RELEASE Authorization

NAME:_____ DATE OF BIRTH:_____

AUTHORIZES: ROHIT PATEL, DDS
BROADWAY COSMETIC DENTISTRY
128 SOUTH BROADWAY TARRY TOWN NY 10591

Send to: _____
Name of Health Care Provider/Plan/Other/ Myself

ADDRESS:
PHONE#:

When transferring information to another dental office, we only send current x-rays (bitewing x-rays, full mouth X-rays & panorex) within the last 5 years and treatment dates for prophy's (cleanings) - exams - scale & root planning. To send just this basic information described above please check here ☐

EXPIRATION: This Authorization is good for one year unless dates filled in below.

SIGNATURE OF PATIENT: _____ DATE: _____

INFORMATION TO BE DISCLOSED:
Specific records/information as follows: _____
_____

I DON'T WANT THE FOLLOWING INFORMATION DISCLOSED:
_____
_____

By signing, I understand that the information released per this authorization, is no longer protected by: Rohit Patel, DDS o confirm my appointments, treatment, and billing.

Dental Insurance

Insurance Company: _____

Subscriber: _____

Relationship to Patient: _____

Birthdate_____

Member ID/ SSN: _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Insurance Company: _____

Subscriber: _____

Relationship to Patient: _____

Birthdate: _____

Member ID/ SSN: _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with_____ and assign directly to Dr. _____ 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 may use my health care information and may disclose such information to the above-named Insurance Company (ies) 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 my current treatment is completed or one year from the date signed below.

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WELCOME

TO BETTER SERVE YOU PLEASE BE ADVISED OF THE FOLLOWING:

Our mission is to practice complete dental healthcare. Our goal is to provide each of our patients with the highest quality dental care in the most comfortable, gentle manner possible. We are committed to delivering your care with warmth and compassion and seek to prevent any dental problems in the future. Therefore, it is necessary for each patient to have a comprehensive examination. The full treatment plan, associated fees and payment arrangements will be presented at that time.

PLEASE BE AWARE:

The treatment plan prescribed by your dentist is in his/her opinion the best treatment for your dental health. During the course of your treatment there may be unforeseen complications that will change the financial outcome the patient will be responsible for. These additional fees can include laboratory, office time and any extended dental treatment. Rest assured, you will be informed if any changes occur in your existing treatment financial plan.

PLEASE BE CONFIDENT THAT YOU WILL RECEIVE THE BEST DENTAL CARE AVAILABLE.

All fees are due and payable at the time of service, unless prior arrangements have been made.

I have read and fully understand all the above information and agree to comply with all office procedures.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE

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No Show, Missed Appointment Office Policy Form

When our office books your appointment, we are setting aside a dedicated time slot just for you. We only ask that if you must reschedule your appointment, that you please provide us with at least 24 hours notice. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept.

Every patient in our practice receives this unique reservation. When your appointment is made, a time is reserved, your materials are ordered, and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

NO SHOW POLICY

A 'no show' is an appointment that was not cancelled in advance (minimum of 24 hours in advance.) No shows inconvenience other patients who need dental care. A 'no show' for a scheduled appointment or a cancellation on the same day of a scheduled appointment will result in a fee of $100.

Thank you for choosing Broadway Cosmetic Dentistry for your dental needs. We look forward to a long lasting relationship with you.

ACKNOWLEDGEMENT

My signature below indicates that I have read, understand, and agree to the appointment policy above.

Patient Signature _____ Date _____

FINANCIAL AGREEMENT

Patient Name _____ Date _____

We welcome you and your family to Broadway Cosmetic Dentistry! We look forward to providing superior, compassionate dental care at affordable prices. To provide you with the most beneficial and comprehensive service, we request that you review and sign our financial agreement form. We are happy to answer any questions you may have regarding the proposed treatment and available financial options.

Please take note of the following:

- We will always do our best to help you maximize your dental insurance benefits.
- If you are using a credit card to pay for rendered treatment, there is a 4% service fee which will be added to your financial statement.
- If you are using a financing option, such as Care Credit or Wells Fargo, there is a 10% service fee which will be added to your final statement.
- As a courtesy, all claims are filed by our office, however it is important to understand that your dental insurance policy is a contract between you, your employer and the insurance company.
- Your treatment plan is individually tailored and is never based on your dental insurance
- Not all services are considered 'covered benefits' under your dental policy. Unfortunately, insurance companies arbitrarily select services they won't cover or partially cover.
- It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy - i.e. procedure downgrades, coverage changes, exclusions/limitations, etc.
- Dental coverage issues can only be addressed by your employer or group plan administrator. We cannot act as a mediator between the carrier and your employer.
- At the time of treatment, you are responsible for payment of any applicable deductible and estimated co-insurance portion. Any payments made directly to you by the insurance company on unpaid balances should be forwarded immediately to our office so that your account may be credited accordingly.
- Please feel free to contact your insurance company regarding unpaid benefits. We will gladly provide you with all necessary documentation to assist you.

By signing below, I fully understand all the general insurance related details above. I agree to the financial policy of the office and comprehend the financial portion that I am liable for. Furthermore, I understand that should there be any amount of the estimated co-insurance which was unpaid by the insurance company, I am liable for the entire remaining amount.

I agree to pay for all treatment in a timely fashion as described above.

Patient/Legal Guardian: _____ Date: _____

Witness: _____ Date: _____

Dental History

Reason for Today's visit: _____

Former Dentist: _____

City: _____

State: _____

Date of last dental visit: _____

Date of last dental x-rays: _____

Place a mark on yes or no to indicate if you have had any of the following:

Bad Breath: □ Yes □No	Jaw Pain or Tiredness: □Yes □No
Bleeding Gums: □ Yes □No	Lip or Cheek Biting: □Yes □No
Blisters On Lips or Mouth: □ Yes □No	Loose Teeth or Broken Fillings: □Yes □No
Burning Sensation On Tongue: □Yes □No	Mouth Breathing: □Yes □No
Chew On One Side of Mouth: □Yes □No	Mouth Pain, Brushing: □Yes □No
Cigarette, Pipe, Or Cigar Smoking: □Yes□No	Orthodontic Treatment: □Yes □No
Clicking or Popping Jaw: □Yes □No	Pain Around Ear: □Yes □No
Dry Mouth: □Yes □No	Periodontal Treatment: □Yes □No
Fingernail Biting: □Yes □No	Sensitivity to Cold: □Yes □No
Food Collection Between the Teeth: □Yes □No	Sensitivity to Hot: □Yes□No
Foreign Objects: □Yes □No	Sensitivity to Sweets: □Yes □No
Grinding Teeth: □Yes □No	Sensitivity When Biting: □Yes □No
Gums Swollen Or Tender: □Yes□No	Sores Or Growth In Your Mouth: □Yes □No

How often do you floss: _____?

Health History

Physician's Name: _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. □Yes □No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (Brand names of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine) □Yes □No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV: □Yes □No	Epilepsy: □Yes □No	Respiratory Disease: □Yes □No
Anemia: □Yes □No	Fainting or dizziness: □Yes □No	Rheumatic Fever: □Yes □No
Arthritis, Rheumatism: □Yes □No	Glaucoma: □Yes □No	Scarlet Fever: □Yes □No
Artificial Heart Valves: □Yes □No	Headaches: □Yes □No	Shortness of Breath: □Yes □No
Artificial Joints: □Yes □No	Heart Murmur: □Yes □No	Sinus Trouble: □Yes □No
Asthma: □Yes □No	Heart Problems: □Yes □No	Skin Rash: □Yes□No
Back Problems: □Yes □No	Hepatitis Type__: □Yes □No	Special Diet: □Yes □No
Bleeding abnormally, with extractions or surgery: □Yes □No	Herpes: □Yes □No	Stroke: □Yes □No
	High Blood Pressure: □Yes □No	Swollen Feet or Ankles: □Yes □No
Blood Disease: □Yes □No	Jaundice: □Yes □No	Swollen Neck Glands: □Yes □No
Cancer: □Yes □No	Jaw Pain: □Yes □No	Thyroid Problems: □Yes □No
Chemical Dependency: □Yes □No	Kidney Disease: □Yes □No	Tonsillitis: □Yes □No
Chemotherapy: □Yes □No	Liver Disease: □Yes □No	Tuberculosis: □Yes □No
Circulatory Problems: □Yes □No	Low Blood Pressure: □Yes □No	Tumor or growth on head or neck: □Yes □No
Congenital Heart Lesions: □Yes □No	Mitral Valve Prolapse: □Yes □No	
Cortisone Treatments: □Yes □No	Nervous Problems: □Yes □No	Ulcer: □Yes □No
Cough, Persistent or bloody: □Yes □No	Pacemaker: □Yes □No	Venereal Disease: □Yes □No
	Psychiatric Care: □Yes □No	Weight Loss, unexplained: □Yes□No
Diabetes: □Yes □No	Radiation Treatment: □Yes □No	
Emphysema: □Yes □No		

Do you wear contact lenses: □Yes □No

Women:

Are you pregnant? □Yes □No Due Date: _____ Are you nursing? □Yes □No

Taking birth control pills? □Yes □No

MEDICATION

List any medications you are currently taking and the correlating diagnosis:

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other