Patient Registration

Patient Information

Last Name _____First_____MI_____ Date_____

Address _____

City _____ State _____ Zip Code _____

Mobile # (_____)_____Home Phone # (_____)_____

E-Mail Address _____ Did you visit our website (www.lakeplacidsmiles.com)? _____

Date of Birth _____/_____/_____Social Security # _____-_____-_____ Sex M F Single _____Married _____

Place of Employment _____ Work Phone # (_____)_____Ext#_____

Who referred you to our office? Dr. _____ Friend/Family _____Other _____

Spouses/Guardian Information

Last Name _____First_____MI____ Date of Birth _____/_____/_____

Address _____

City _____ State _____ Zip Code _____

Mobile # (_____)_____Home Phone # (_____)_____ E-

Mail Address _____ Social Security #---------- _____

Place of Employment _____ Work Phone # (_____)_____Ext#_____

If you are completing this form for another person, what is your relationship? _____

Dental Insurance Information

Primary Dental Insurance

Insured's Name _____

Insured's Date of Birth _____

Dental Insurance Company _____

Insurance Co Address _____

_____

Insurance Co Phone # _____

Insured's I.D. # _____

Group # _____

Lake Placid Dental does not participate in any dental insurance plans. *If you have dental insurance, we will file the claim electronically for you. Full payment is required at the time of service and any insurance reimbursement will be sent to you directly by your insurance.*

Signature of Patient or Guardian_____

Secondary Dental Insurance

Insured's Name _____

Insured's Date of Birth _____

Dental Insurance Company _____

Insurance Co Address _____

Insurance Co Phone # _____

Insured's I.D. # _____

Group # _____

LAKE PLACID DENTAL
MARA MARIANI, DDS

LAKE PLACID DENTAL
MARA MARIANI, DDS

MEDICAL HISTORY

Patient Name:_____ Date of Birth: _____

Physician's Name _____ Date of Last Visit with Family Doctor: _____

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	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Heart Valve	☐ 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	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor Growth	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cough, Persistent or Bloody	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Pace Maker	☐ Yes ☐ No	Weight Loss, Unexplained	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No

Have you ever taken Bisphosphonates? ☐ Yes ☐ No Examples: *Actonel, Zometa, Fosamax and Boniva*

Women:
Are you Pregnant? ☐ Yes ☐ No Due Date:_____
Are you Nursing? ☐ Yes ☐ No
Taking Birth Control Pills? ☐ Yes ☐ No

Medications (With Dosage)	Allergies
List any medications you are currently taking:	☐ Aspirin ☐ Local Anesthetic
_____	☐ Barbiturates (sleeping pills) ☐ Penicillin
_____	☐ Codeine ☐ Sulfa
_____	☐ Iodine ☐ Other
_____	☐ Latex _____
_____	☐ Metals _____
_____	☐ Plastics

Do you have any disease or condition not listed on this form? ☐ Yes ☐ No
If "Yes", Explain:_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or Medication.

_____ _____
Patient's Signature or Guardian of Patient Date

LAKE PLACID DENTAL
MARA MARIANI, DDS

DENTAL HISTORY

Patient Name:_____ Date of Birth: _____

What brings you in today:_____

When was your last visit to the dentist:_____ What was done at that visit:_____

Your previous Dentist: (name and location)_____

Have you had a complete series of dental x-rays taken: ☐ Yes ☐ No...If yes, When:_____

How often do you brush your teeth _____ How often do you floss_____

What dental aids to you use to help clean your teeth: (toothbrush, floss, etc....)_____

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

Have you ever been told to take antibiotics prior to dental treatment?..... ☐ Yes ☐ No
Do your gums bleed or hurt?..... ☐ Yes ☐ No
Have your parents experienced gum disease or tooth loss?..... ☐ Yes ☐ No
Have you noticed any loose teeth or change in your bite?..... ☐ Yes ☐ No
Does food tend to become caught in between your teeth?..... ☐ Yes ☐ No
If yes, Where_____

Are any of your teeth sensitive to:

Hot or cold liquids/food?..... ☐ Yes ☐ No
Sweet or sour liquids/food?..... ☐ Yes ☐ No
Biting or chewing?..... ☐ Yes ☐ No

Have you ever had:

Orthodontic treatment?..... ☐ Yes ☐ No
Oral Surgery?..... ☐ Yes ☐ No
Periodontal treatment?..... ☐ Yes ☐ No
Your bite adjusted?..... ☐ Yes ☐ No
A bite plate or mouth guard?..... ☐ Yes ☐ No
A serious injury to the mouth or head?..... ☐ Yes ☐ No
Please describe:_____

Do you:

Clench or grind your teeth while awake or asleep?.... ☐ Yes ☐ No
Bite your lips or cheeks regularly?..... ☐ Yes ☐ No
Hold foreign objects with your teeth?..... ☐ Yes ☐ No
Mouth breathe while awake or asleep?..... ☐ Yes ☐ No
Have tired jaws, especially in the morning?..... ☐ Yes ☐ No
Play a contact sport?..... ☐ Yes ☐ No
Snore or have any other sleeping disorders?..... ☐ Yes ☐ No
If you have sleep apnea how severe is it:_____

Have you experienced:

Mouth odors or bad tastes..... ☐ Yes ☐ No
Frequent cold sores, blisters..... ☐ Yes ☐ No
Clicking or popping of the jaws?..... ☐ Yes ☐ No
Pain (joint, ear, side of face)?..... ☐ Yes ☐ No
Difficulty in opening or closing the mouth?..... ☐ Yes ☐ No
Difficulty in chewing?..... ☐ Yes ☐ No
Headaches, neck aches or shoulder aches?. ☐ Yes ☐ No
Sore muscles (Neck, shoulders)?..... ☐ Yes ☐ No
Any unusual conditions in your mouth..... ☐ Yes ☐ No

Do you smoke/chew tobacco or use other tobacco products?.... ☐ Yes ☐ No
If yes, how much and for how many years_____

Are you satisfied with your teeth's appearance?..... ☐ Yes ☐ No
If no, Please describe_____

Do you feel nervous about dental treatment?..... ☐ Yes ☐ No
If yes, Please describe_____

Have you ever had an upsetting dental experience?..... ☐ Yes ☐ No
If yes, Please describe_____

Is there anything else about having dental treatment that you would like us to know?..... ☐ Yes ☐ No

If yes, Please describe_____

LAKE PLACID DENTAL
MARA MARIANI, DDS

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 07/01/2013, 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 changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a 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 at alternative locations, you may complain to us using the 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 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.

Our Privacy Official: Office Manager
Telephone: 518-523-2406
Address: 2358 Saranac Ave, Lake Placid NY 12946
E-mail: officemanger@lakeplacidsmiles.com

LAKE PLACID DENTAL
MARA MARIANI, DDS

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgement*

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) Specify)

LAKE PLACID DENTAL
MARA MARIANI, DDS

CANCELLATION POLICY

Our goal is to provide quality dental care to our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other scheduled patients as well. Please be aware of our policy regarding cancellations, missed appointments and late arrivals.

Our office requests **2 business day** cancellation notice prior to all scheduled appointments. To ensure that all appointment cancellations are processed in a timely manner, **we will no longer accept cancellations via voicemail or email**. All cancellations must be made by **speaking directly with a team member during our business hours**. This will allow us to offer your appointment to another patient in need. Failure to do so will result in a $63.00 cancellation fee, which must be paid prior to rescheduling the failed appointment.

Please arrive promptly for your scheduled appointment time. Late arrival may be subject to rescheduling.

By signing this form, you are acknowledging the cancellation policy and accepting responsibility.

Signature: _____ **Date:** _____

2358 Saranac Ave ♦Lake Placid, New York 12946♦(518) 523-2406