# METROPOLITAN DENTAL ASSOCIATES

PATIENT NAME: ______________________________ CHART# ____________ DATE: ____________
LAST FIRST MI

MALE FEMALE MARRIED SINGLE CHILD OTHER ______________________

SOCIAL SECURITY# ____________ DATE OF BIRTH ____________ E-MAIL ADDRESS ____________

PHONE# (HOME) ____________ WORK ____________ EXT ______ CELL ____________

ADDRESS ______________________________
STREET APT# CITY STATE ZIP

## I. CHECK APPROPRIATE ANSWER (Leave blank if you do not understand the question)

YES NO IS YOUR GENERAL HEALTH GOOD?
YES NO HAS THERE BEEN A CHANGE IN YOUR HEALTH WITHIN THE LAST YEAR?
YES NO HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS IN THE LAST THREE YEARS?
WHY? ______________________________
YES NO ARE YOU BEING TREATED BY A PHYSICAN NOW? FOR WHAT? ______________________________
DATE OF LAST MEDICAL EXAM? ____________DATE OF LAST DENTAL APPOINTMENT? ____________
PHYSICAN'S NAME ______________________ PHONE ______________________
YES NO HAVE YOU HAD PROBLEMS WITH PRIOR DENTAL TREATMENT?
YES NO ARE YOU IN PAIN NOW? PLEASE EXPLAIN: ______________________________

## II. HAVE YOU EXPERIENCED

| | | | | | | |
|---|---|---|---|---|---|---|
| YES | NO | CHEST PAIN (ANGINA)? | YES | NO | DIZZINESS? | TEMP ______ |
| YES | NO | SWOLLEN ANKLES? | YES | NO | RINGING IN EARS? | RESP ______ |
| YES | NO | SHORTNESS OF BREATH? | YES | NO | HEADACHES? | PULSE ______ |
| YES | NO | RECENT WEIGHT LOSS, FEVER, NIGHT SWEATS? | YES | NO | FAINTING SPELLS? | BP ______ |
| YES | NO | PERSISTENT COUGH, COUGHING UP BLOOD? | YES | NO | BLURRED VISION? | |
| YES | NO | BLEEDING PROBLEMS, BRUISE EASILY? | YES | NO | SEIZURES, EPILEPSY? | |
| YES | NO | SINUS PROBLEMS? | YES | NO | EXCESSIVE THIRST? | |
| YES | NO | DIFFICULTY SWALLOWING? | YES | NO | FREQUENT URINATION? | |
| YES | NO | DIARRHEA, CONSTIPATION, BLOOD IN STOOLS? | YES | NO | DRY MOUTH? | |
| YES | NO | FREQUENT VOMITING OR NAUSEA? | YES | NO | JAUNDICE? | |
| YES | NO | DIFFICULTY URINATING, BLOOD IN URINE? | YES | NO | JOINT PAIN, STIFFNESS? | |

## III. DO YOU HAVE OR HAVE YOU EVER HAD? (Please check the appropriate answer)

| | | | | | |
|---|---|---|---|---|---|
| YES | NO | HEART DISEASE? | YES | NO | AIDS, ARC, HIV INFECTION? |
| YES | NO | HEART ATTACK, HEART DEFECTS? | YES | NO | TUMORS, CANCER? |
| YES | NO | HEART MUMURS, MITRAL VALVE PROLAPSE? | YES | NO | ARTHRITIS, RHEUMATISM? |
| YES | NO | RHEUMATIC FEVER? | YES | NO | EYE DISEASES? |
| YES | NO | STROKE, HARDENING OF THE ARTERIES? | YES | NO | ANEMIA, BLOOD DISEASE? |
| YES | NO | HIGH BLOOD PRESSURE? | YES | NO | STD? |
| YES | NO | TB, EMPHYSEMA, OTHER LUNG DISEASE? | YES | NO | HERPES? |
| YES | NO | HEPATITIS, OTHER LIVER DISEASE, JAUNDICE? | YES | NO | KIDNEY, BLADDER DISEASE? |
| YES | NO | STOMACH PROBLEMS, ULCERS? | YES | NO | THYROID, ADRENAL DISEASES? |
| YES | NO | FAMILY HISTORY OF DIABETES, HEART PROBLEMS, TUMORS? | YES | NO | DIABETES? |
| YES | NO | PRE-MEDICATED PRIOR TO DENTAL VISIT? | YES | NO | MOUTH-BREATHING? |

**PLEASE CIRCLE ALLERGIES**: LATEX, METALS, PENICILLIN, FOODS, DRUGS, MEDICATIONS, OTHER? PLEASE LIST ALL: ____________

## IV. DO YOU HAVE OR HAVE YOU EVER HAD? (*Please check the appropriate answers*)

| | | | | | |
|---|---|---|---|---|---|
| YES | NO | PSYCHIATRIC CARE? | YES | NO | HOSPITALIZATION? |
| YES | NO | RADIATION TREATMENTS? | YES | NO | BLOOD TRANSFUSION? |
| YES | NO | CHEMOTHERAPY? | YES | NO | SURGERIES? |
| YES | NO | PROSTHETIC HEART VALVE? | YES | NO | PACEMAKER? |
| YES | NO | ARTIFICIAL JOINT? | YES | NO | CONTACT LENSES? |

## V. DO YOU USE?

| | | | | | |
|---|---|---|---|---|---|
| YES | NO | RECREATIONAL DRUGS? | YES | NO | TOBACCO IN ANY FORM? |
| YES | NO | ANTICOAGULANT MEDIICATION? | YES | NO | ALCOHOL? |

**PLEASE LIST ALL DRUGS, MEDICATIONS, OVER THE COUNTER MEDICATIONS, ASPIRIN, PHEN-FEN, DIET PILLS, SUPPLEMENTS, VITAMINS, HERBAL REMEDIES:** ______________________________

## VI. PLEASE CHECK THE APPROPRIATE ANSWERS

YES NO ARE YOU PREGNANT OR NURSING? YES NO TAKING BIRTH CONTROL?
IF SO, PLEASE EXPLAIN: ______________________________
YES NO DO YOU HAVE OR HAVE YOU ANY OTHER DISEASES OR MEDICAL PROBLEMS **NOT** LISTED ON THIS FORM?
IF SO, PLEASE EXPLAIN: ______________________________

**TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED EVERY QUESTION COMPLETELY AND ACCURATELY. I WILL INFORM MY DENTAL PROVIDER OF ANY CHANGE IN MY HEALTH AND MEDICATION.**

______________________________ ______________________________
PATIENT'S (Parent/Guardian) SIGNATURE DATE DOCTOR'S SIGNATURE DATE

# METROPOLITAN DENTAL ASSOCIATES

## DENTAL INSURANCE INFORMATION

**If you DO NOT have dental insurance, skip to Medical Insurance Information**

The following information is on the insured person:

Name: ____________________________________________ Relation to Patient: ______________________________

Social Security #_______________________________________ Birth Date: _________________________________

Phone (Home): _________________________________ (Work) ________________________ Ext _______________

Address: ___________________________________________________________________________________
Street Apt City State Zip Code

**Primary Dental Insurance Information**
My Primary Dental Insurance Company Is: ____________________________________________________________

**Employment Information of Insured**
Employer Name: _______________________________________ Occupation _______________________________

Address: ___________________________________________________________________________________
Street City State Zip Code

**Secondary Dental Insurance Information:**

Name of Insured: ______________________________________________________________________________
Last First MI

Patient's relationship to insured: ( ) Self ( ) Spouse ( ) Child Other _____________________________________

Insured's Birth Date: _______________________________________ ID#: ___________________________________

Insured's Employer Name: ____________________________________ Group# _________________________________

Insurance Company Name and Address: ________________________________________________________________

**Medical Insurance Information**

I have medical insurance coverage.
I do not have medical insurance coverage

Name of Medical Insurance Coverage: _________________________________________________________________

Medical Insurance Company: ________________________________________________________________________

Name of Insured: ____________________________________________ Group#: ______________________________

Insured's ID Number: ___________________________________________________________________________

Employer Who the Medical Insurance is Through: ________________________________________________________

# Metropolitan Dental Associates

## Financial Responsibility

**Payment is expected in full at time of service**

**Please remember that we bill insurance companies as a courtesy to the patient and that you ultimately are responsible for all fees incurred in our office!**

I understand that by signing below I am allowing Metropolitan Dental Associates to use the supplied information to bill insurance coverage for any services rendered and that my insurance company may send that benefit to Dental Specialty Associates (Assignment of Insurance Benefits). I also understand that any co-payments, percentages or fee schedule payments are due from me at time of service.

I am ultimately responsible for any and all balances on my account incurred in any way. I am responsible for any non-covered services, and any balances remaining after my insurance company has paid their portion.

It is my responsibility to keep my coverage active, to be familiar with my plans benefits and to know that I am covered at the time that services are rendered. Any claims denied or unpaid due to my coverage not being in force at time of services, or any other reason will be billed directly to me. It is also my responsibility to ask for a quote on any dental services before they are rendered.

_______________________________________________________ **Date**___________________

*Signature of patient (or legal guardian if minor)*

### Patient Confidentiality Policy

As our patient we want you to know that we respect the privacy of your personal information. The information you supply to us is used to carry out treatment, payment and any healthcare related operations. Use of your personal information for other purposes would require your authorization. We strive to always take reasonable precautions to protect your privacy as outlined under the HIPPA (Health Insurance Privacy and Portability Act) guidelines. We also have to right to change or amend or privacy practices. We support your right to access to your personal dental records. Our office charges fee for record copies.
You have the right to review our privacy notice, and to revoke consent in writing at any time after reviewing our privacy policies. If you have questions about our privacy policies please ask to speak to our HIPAA compliance officer on staff. Our complete privacy policies are available for reading if desired.

**Print name of patient:** ________________________________________

**Signature:** ________________________________________________ **Date**________________

***Patient signature (parent or legal guardian)***

### Consent for Services

As a condition of our treatment, financial arrangements must be made in advance. All emergency dental services, or any dental services performed, must be paid at the time services are performed.

We will help prepare the patients insurance forms. However, we cannot render services on the assumption that our charges will be paid in full by any insurance company.

I understand that treatment plans are estimates only and subject to change depending on unforeseen circumstances that may arise during the course of treatment.

I understand that the fees estimated for dental services can only be extended for a period of six months from the date of the patient examination.

I understand as a courtesy I should give at least 24 hours notice for all appointment changes.

I grant my permission to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their consent.

__________________________________________ **Date:** ____________ **Relationship to Patient**____________________________

***Signature of patient, parent or guardian***

__________________________________________ **Date:** ____________ **Relationship to Patient**____________________________

***Signature of guarantor of payment/responsible party***

METROPOLITAN DENTAL ASSOCIATES

# 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.

________________________________________
{Please 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)

________________________________________

________________________________________

________________________________________

METROPOLITAN DENTAL ASSOCIATES

# 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, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (MM/DD/YR), 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that 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 healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician 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, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** 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 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 use 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 must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the 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 person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. 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 filled prescriptions, medical supplies, 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 your health or safety 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 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 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 messages, postcards, or letters).

## 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 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 may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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 will 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 a 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 disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 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).

**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.}** 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 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 the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

## QUESTIONS AND COMPLAINTS

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

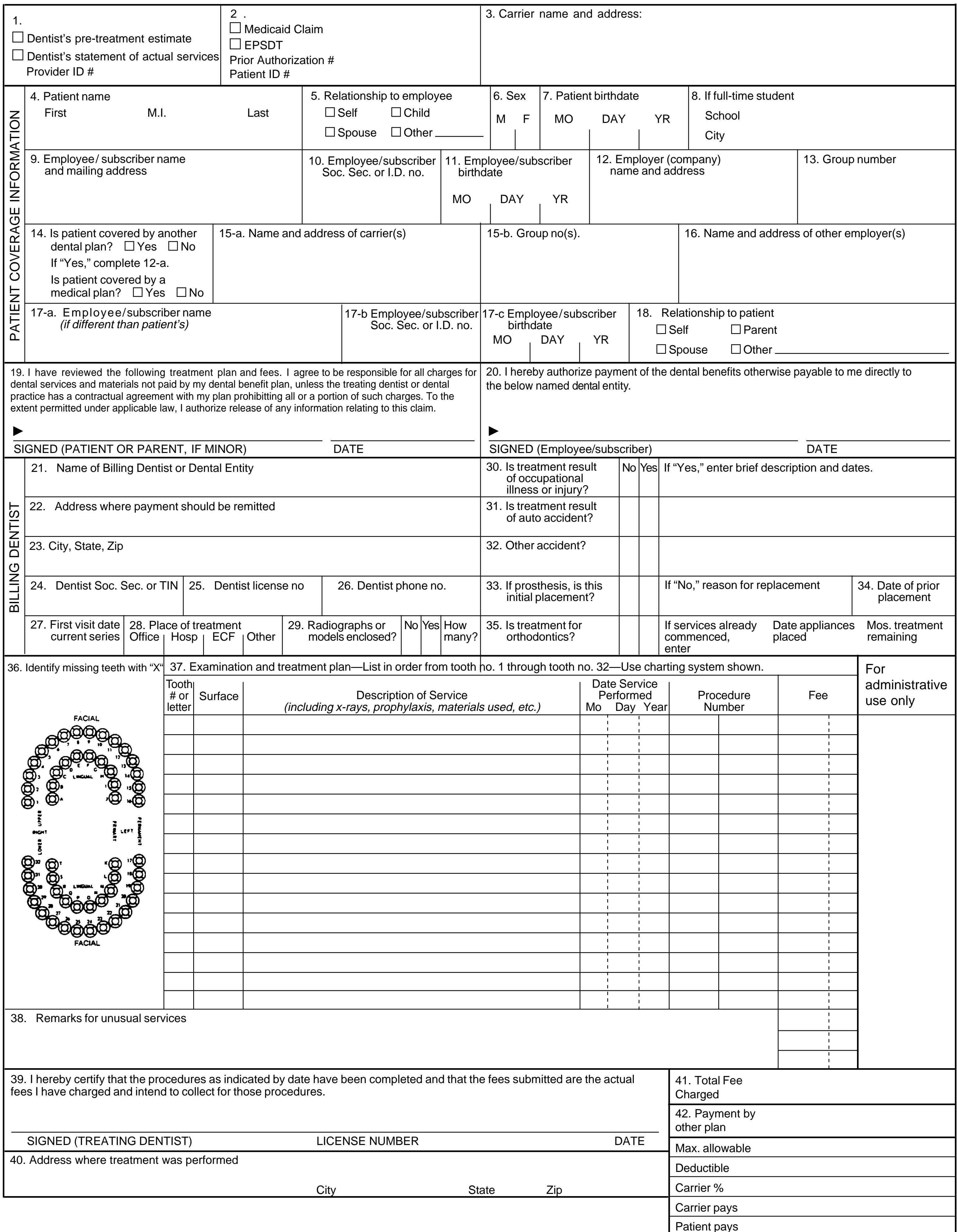
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative 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.

Contact Officer: **Mario Orantes** Address: 225 Broadway New York, NY 10007

E-mail: mario@metropolitandental.com Telephone: (646) 839-8400 Fax: (212) 732-0267

# Dental Claim Statement



1.
☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services
Provider ID #

2.
☐ Medicaid Claim
☐ EPSDT
Prior Authorization #
Patient ID #

3. Carrier name and address:

**PATIENT COVERAGE INFORMATION**

4. Patient name
First M.I. Last

5. Relationship to employee
☐ Self ☐ Child
☐ Spouse ☐ Other ______

6. Sex
M F

7. Patient birthdate
MO DAY YR

8. If full-time student
School
City

9. Employee/subscriber name and mailing address

10. Employee/subscriber Soc. Sec. or I.D. no.

11. Employee/subscriber birthdate
MO DAY YR

12. Employer (company) name and address

13. Group number

14. Is patient covered by another dental plan? ☐ Yes ☐ No
If "Yes," complete 12-a.
Is patient covered by a medical plan? ☐ Yes ☐ No

15-a. Name and address of carrier(s)

15-b. Group no(s).

16. Name and address of other employer(s)

17-a. Employee/subscriber name *(if different than patient's)*

17-b Employee/subscriber Soc. Sec. or I.D. no.

17-c Employee/subscriber birthdate
MO DAY YR

18. Relationship to patient
☐ Self ☐ Parent
☐ Spouse ☐ Other ______

19. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibitting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

► ______________________ ______________
SIGNED (PATIENT OR PARENT, IF MINOR) DATE

20. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

► ______________________ ______________
SIGNED (Employee/subscriber) DATE

**BILLING DENTIST**

21. Name of Billing Dentist or Dental Entity

22. Address where payment should be remitted

23. City, State, Zip

24. Dentist Soc. Sec. or TIN

25. Dentist license no

26. Dentist phone no.

27. First visit date current series

28. Place of treatment
Office Hosp ECF Other

29. Radiographs or models enclosed? No Yes How many?

| | No | Yes | |
|---|---|---|---|
| 30. Is treatment result of occupational illness or injury? | | | If "Yes," enter brief description and dates. |
| 31. Is treatment result of auto accident? | | | |
| 32. Other accident? | | | |
| 33. If prosthesis, is this initial placement? | | | If "No," reason for replacement / 34. Date of prior placement |
| 35. Is treatment for orthodontics? | | | If services already commenced, enter / Date appliances placed / Mos. treatment remaining |

36. Identify missing teeth with "X"



37. Examination and treatment plan—List in order from tooth no. 1 through tooth no. 32—Use charting system shown.

| Tooth # or letter | Surface | Description of Service *(including x-rays, prophylaxis, materials used, etc.)* | Date Service Performed Mo | Day | Year | Procedure Number | Fee |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
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For administrative use only

38. Remarks for unusual services

39. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

SIGNED (TREATING DENTIST) LICENSE NUMBER DATE

40. Address where treatment was performed

City State Zip

41. Total Fee Charged

42. Payment by other plan

Max. allowable

Deductible

Carrier %

Carrier pays

Patient pays