New Patient Profile

Dr. Derek Faktor

Date: _____

Name: _____
Last **First** **MI**

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (*Home*): [____]_____(*Work*): [____]_____(*Cell*): [____]_____

E-mail address: _____@_____

Sex: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other: _____

Company Name & Address: _____

Occupation: _____

Date of Birth: ____/____/____Age: _____S.S.# _____-____-_____

Referred By: _____

In case of emergency, contact _____ Telephone:_____

Date of last dental examination: _____

Date of last series of complete mouth x-rays: _____

Are you in good health?	Yes	No
Has there been any change in your general health within the past five years?	Yes	No
Do your gums bleed when you brush?	Yes	No
Are you happy with your Smile?	Yes	No
Do you smoke cigarettes, cigars, or pipes?	Yes	No
Are your teeth Yellow?	Yes	No
Would you like to change your Smile?	Yes	No
Whiten your teeth?	Yes	No
Do you have any problem eating certain foods?	Yes	No
Do you have sensitivity to hot or cold foods?	Yes	No
Have you ever been Pre-Medicated with antibiotics before any dental treatment ?	Yes	No
Did you ever have orthodontics?	Yes	No
If yes, how many years_____at what age_____?		

List ALL hospitalizations and serious illnesses, including dates:

_____ _____

_____ _____

_____ _____

Continue →

Do you have or ever had any of the following:

Diagnosed with a Heart Murmur/Mitral Valve?	☐	Rheumatic Fever or Rheumatic Heart Disease?	☐
Heart attack, angina, or other heart disease?	☐	Prosthetic or Artificial heart valve?	☐
Irregular heartbeat or pacemaker?	☐	Shortness of breathes after mild exercise?	☐
High Blood Pressure?	☐	Swollen Ankles	☐
Asthma, emphysema, or difficulty breathing?	☐	Recent increase in thirst?	☐
Stroke, seizures, or convulsions?	☐	Stomach ulcers or stomach problems?	☐
Diabetes?	☐	AIDS, ARC, HIV infection?	☐
Recent increase in urination?	☐	Arthritis or rheumatism?	☐
Thyroid Problems?	☐	Prosthetic or Artificial joint?	☐
Kidney trouble or Renal Dialysis?	☐	Cancer, radiation treatment, or chemotherapy	☐
Hepatitis, liver disease, or jaundice?	☐	Venereal disease? Syphilis? Gonorrhea?	☐
Tuberculosis?	☐	Persistent cough or coughing up blood?	☐
Psychiatric treatment?	☐	Enlarged lymph nodes or swollen glands?	☐
Autoimmune disease or lupus erythematousus?	☐	Hearing problem or vision problems?	☐
Blood disorder, bleeding tendency or frequent bruising?	☐		

Do you have any allergies? Yes No

If yes, what? _____

Have you ever taken penicillin? Yes No

Have you ever had a bad reaction to any drug or medication? Yes No

If yes, what? ☐Penicillin or other antibiotic ☐Aspirin
☐ Dental anesthetic ☐Codeine or other narcotics
☐Other_____

[WOMEN ONLY] Are you pregnant? Yes No

List all of the drugs or medications you are taking now.

Name of Medication	Dosage	How Long	Reason

Are you under the care of a physician? ☐Yes ☐No

Please provide the MD's name, address and phone number:

_____

Continue →

In addition to those you have listed, have you taken any of the following medications or drugs within the past year? If yes please check the appropriate box.

- ☐ Medication for asthma
- ☐ Medication for anxiety (nerves)
- ☐ Medication for depression or a disorder
- ☐ Medication for a heart problem
- ☐ Nitroglycerin or any medication for angina or chest pain
- ☐ Anticoagulants (blood thinners)
- ☐ Medication for stomach ulcers
- ☐ Cancer, Chemotherapy
- ☐ Aspirin, arthritis/pain medication
- ☐ Methadone maintenance
- ☐ Cortisone/other steroids
- ☐ Medication for high blood pressure
- ☐ Insulin or pills for diabetes
- ☐ AZT/other drugs for HIV infection
- ☐ Other: _____

I understand and authorize FaktorDMD to take all diagnostic materials needed to make a final diagnosis of dental treatment. Diagnostic materials may include Intra-oral pictures, radiographs, digital radiographs, diagnostic models, photographs and slides. This material may be used for lectures, articles and or publications.

I authorize FaktorDMD to perform and or administer any and all forms of treatment, medication and anesthesia that may be necessary. I understand that the dental treatment presented to me is my financial responsibility and that all fees for services are due and payable up front and/or at the completion of treatment as authorized by FaktorDMD and or administrator.

I will assume responsibility of notifying FaktorDMD of any changes in my medical history or contact information.

I understand that FaktorDMD reserve the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

I hereby acknowledge that I have been provided with a copy of the Notice of Privacy Practices.

We reserve the right to charge our patients a fee for appointments that are broken or not cancelled with 24 hour notice.

Patient's Signature: _____ **Date**: _____

Office Policies

Thank you for choosing our office to provide your dental care. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding and to better serve you, we ask that all patients read and sign our Office Policies.

1. VERIFYING INSURANCE: As a courtesy to you, we will verify your insurance for eligibility benefits prior to your new patient appointment as well as any time that you notify us of a change in your coverage. The insurance companies do not guarantee payment based on the information that they provide us. **You are ultimately responsible** for knowing if there are any waiting periods for work to be performed. Any amounts on your treatment plans that are not covered by your insurance, are your financial responsibility.

2. PAYMENT: Payment is due **at the time of service.** Additionally, if you have a balance following an insurance payment from a previous visit, you will be expected to pay that amount as well.

3. INSURANCE INFORMATION: New Insurance as well as **changes in INSURANCE** must be provided to this office prior to an appointment. Failure to provide correct and current insurance information may result in the entire bill being **your** responsibility.

4. CHANGES IN PERSONAL INFORMATION: Changes in your address or telephone numbers should be kept current with our office.

5. REQUESTS FOR ADDITIONAL INFORMATION: These must be responded to **immediately.** Such requests include proof of a college student's full-time status and proof of continued enrollment in an insurance plan. Failure to provide this information to the insurance company in a timely manner may result in the entire balance being your responsibility.

6. PAYMENT PLANS: Our office offers Third Party Financing if needed to assist you in paying for any necessary treatment.

7. BALANCES: If your account balance exceeds 90 days, you will receive a notice informing you that your account is **overdue and a $50 collections surcharge may be added to your account.** If you do not pay your balance or arrange a payment plan within 30 days, your account will be turned over to a collections agency. If this happens, the collection agency will report any unpaid balance to the major credit bureaus.

8. RETURNED CHECKS: There will be a **$30** fee for all returned checks. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash or credit card. Once a check has been returned, this office will no longer accept personal checks for payment.

9. CANCELLATIONS / FAILED APPOINTMENTS: We request **24-hours notice** if you are cancelling an appointment.

I believe that I may have a condition requiring dental care, do, as a condition of my treatment hereby voluntarily consent to such dental care at FaktorDMD ("Office") encompassing diagnostic procedures and dental treatment (including medication) by members of the dental staffs of the Office designees as is necessary in their judgment of those involved in treatment.
I understand that emergency care is available twenty-four hours per day.
I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations in the Office

Thank you for reading this information in full. Please sign below to acknowledge your understanding of our office policy and consent for treatment.

Patient or Guardian Signature _____

Date _____

Patient Name (Please Print) _____

Agreement to Receive Electronic Communication

Until I tell you in writing to stop, I authorize **Faktor DMD** to transmit patient information relating to my treatment, health, or payment by email or other electronic means, such as texting etc. 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 **Faktor DMD's** health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

If you insist on encrypted text or email we will try, if reasonable, otherwise we will use regular mail or fax.

I agree that the dental practice may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling:

FaktorDMD_____ 212-826-2306

Email Address (PLEASE PRINT CLEARLY):

_____@_____

Patient or Guardian Signature:_____

Date:_____

Patient Name (Please Print):_____

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 **09/01/2013**, 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: Cristina Gicu_____

Telephone: 212-826-2306_____ Fax: 212-319-4995_____

Address: 693 Fifth Avenue, 14th Floor____

E-mail: nystaff@faktordmd.com___

Acknowledgement of Receipt of Notice of Privacy Practices

FaktorDMD

_____

{Name of Practice}

* You May Refuse to Sign This Acknowledgment*

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)