WELCOME

In order to ensure your maximum oral health and allow us to prescribe the proper medications, it is very important to that we know all medical and dental information about you. Please check every box on the front and back of this form, even if the answer is "N/A" (not applicable). This information will be kept in the strictest confidence.

You also should know that changes in other parts of your body may affect the oral cavity and what dental treatment can be done, even if they seem unconnected. Cardiac (heart) problems, artificial joints and diabetes are just some examples.

Will you please inform the dentist or the staff at the beginning of each new office visit if your medical or dental conditions have changed since we last saw you? **Yes / No** Thank you.

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip

I prefer to be called: Mr. Mrs. Miss Other _____

Birth Date: _____ Gender: F / M Age: _____

Patient SS#: _____

If patient is a minor, give parent's or guardian's name:

_____

Occupation: _____

Employer: _____

Spouse's Name: _____

Spouse's Occupation: _____

Spouse's Employer: _____

Whom may we thank for referring you? _____

2 Phone Numbers

Home Phone _____

Work _____ Ext. _____

Cell Phone _____

Email Address _____

Spouse's Work _____

Best time and place to reach you _____

Family Physician's name _____

Physician's phone _____

IN CASE OF AN EMERGENCY, CONTACT *(Specify someone who does not live in your household)*

Name _____

Relationship _____

Home Phone _____

3 DENTAL INSURANCE

Who is responsible for this account? _____

SS#: _____ Birth Date _____

Relationship to patient _____

Insurance Co. _____

Group#: _____

Is patient covered by additional insurance? Yes / No

Subscriber's Name _____

Insurance Co. _____

Group#: _____

4 ASSIGNMENT AND RELEASE

I certify that I (or my dependent) have insurance coverage as indicated and assign directly to this office all insurance benefits otherwise payable to me for service rendered. I understand that I am responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____

Relationship to Minor (if applicable) *Date*

WELCOME

WELCOME

1 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

Date of last dental visit _____

Date of last dental x-rays _____

Mark "Yes" or "No" to indicate if you presently have or previously had any of the following:

Bad breath	Yes / No
Bite your lips or cheek regularly	Yes / No
Bleeding gums	Yes / No
Blisters on lips or mouth	Yes / No
Chew on one side of mouth	Yes / No
Dry mouth	Yes / No
Food collection between the teeth	Yes / No
Grinding teeth	Yes / No
Gums swollen or tender	Yes / No
Jaw pain or tiredness	Yes / No
Mouth breathing	Yes / No
Orthodontic treatment	Yes / No
Pain around ear	Yes / No
Periodontal (gum) treatment	Yes / No
Sensitivity to cold	Yes / No
Sensitivity to hot	Yes / No

Have you experienced:

Clicking or popping of the jaw?	Yes / No
Pain? (Joint, ear side of face)	Yes / No
Difficulty in opening and closing of the mouth?	Yes / No

How often do you floss? _____

How often do you brush? _____

Do you require antibiotics before dental treatment? Yes / No

Are you currently in pain? Yes / No

Have you ever had a serious / difficult problem associated with any previous dental work? Yes / No

Do you like your smile? Yes / No

Do you feel nervous about having dental treatment? Yes / No

Have you ever had a bad experience in a dental office? Yes / No
If yes, please describe _____

_____

Is there anything else about having dental treatment that you would like us to know?

_____

_____

2 MEDICAL HISTORY

Your current physical condition is:

___Good ___Fair ___Poor

Are you currently under the care of a physician? Yes / No

Please explain _____

_____

Are you taking any prescription / over the counter drugs? Yes / No
Please list each one:

_____

_____

_____

_____

History of Bisphosphonate (ex. Fosomax) therapy? Yes / No

Do you smoke or use tobacco in any other forms? Yes / No

For Women:

Are you taking birth control pills?	Yes / No
Are you pregnant?	Yes / No
Are you nursing?	Yes / No

Do you have or have you ever had any of the following diseases or medical problems?

Abnormal Bleeding	Yes / No
Alcohol / Drug Abuse	Yes / No
Alzheimer's Disease	Yes / No
Anemia	Yes / No
Arthritis	Yes / No
Artificial Bones / Joints / Valves	Yes / No
Asthma	Yes / No
Blood Transfusion	Yes / No
Bruise Easily	Yes / No
Cancer / Chemotherapy	Yes / No
Colitis	Yes / No
Diabetes	Yes / No
Difficulty Breathing	Yes / No
Emphysema	Yes / No
Epilepsy	Yes / No
Fainting Spells	Yes / No
Frequent Headaches	Yes / No
Glaucoma	Yes / No
Hay Fever	Yes / No
Heart Problems	Yes / No
Heart Murmur	Yes / No
Hemophilia	Yes / No
Hepatitis	Yes / No
Herpes / Fever Blisters	Yes / No
High Blood Pressure	Yes / No
HIV+ / AIDS	Yes / No
Hospitalized for Any Reason	Yes / No
Joint Replacement	Yes / No
Kidney Problems	Yes / No
Liver Disease	Yes / No
Low Blood Pressure	Yes / No
Mitral Valve Prolapse	Yes / No
Nervous / Anxious	Yes / No
Pacemaker	Yes / No
Psychiatric/Psychological Care	Yes / No
Radiation Treatment	Yes / No
Rheumatic/Scarlet Fever	Yes / No
Seizures	Yes / No
Sinus Problems	Yes / No
Stroke	Yes / No
Thyroid Problems	Yes / No
Tuberculosis (TB)	Yes / No
Tumors or Growths	Yes / No
Ulcers	Yes / No
Venereal Disease	Yes / No

Do you have or have you had and disease, condition, or problem not listed? Yes / No

Are you allergic to any of the following?

Aspirin	Yes / No
Codeine	Yes / No
Dental Anesthetics	Yes / No
Latex	Yes / No
Metals	Yes / No
Penicillin	Yes / No
Tetracycline	Yes / No

Please list any other drugs/ materials that you are allergic to:

_____

_____

3

CERTIFICATION: I certify that the answers given are correct to the best of my knowledge.

Signature _____ **Date** _____

WELCOME

Brian M.Kritzman, 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.
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 you 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 1/22/2003, and will remain 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 copies of this Notice, please contact us using the information at the end of this notice.

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

Treatment: We may use of disclose you 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 for 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, training programs, accreditation, certification, licensing or credentialing activities.

Your authorization: In addition to our use of you 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 authorization, you may revoke it in writing at any time. You revocation will not affect any use 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 to do so.

Persons Involved In Care: We may use or disclose health information to notify, or to assist in the notification (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 and 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 the is directly relevant to the persons 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 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 then 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 sign a form to request access by using the contact information listed at the end of this Notice. 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 $.75 for each page, $30 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed. If you request an alternate format, we will charge a cost-based fee for providing your health information in the format you prefer. We will provide a summary or an explanation of your health information for a fee. Contact us by 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 then treatment, payment, healthcare operations and certain other activities for the last six years, but not before April 14, 2003. If you request this accounting more then once in a six year period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: 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 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 alternate 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 you must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you request this Notice on our Website or by electronic mail (e-mail), you are entitled to see 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 of 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 may also submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US 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 US Department of Health and Human Services.

Brian M. Kritzman DDS
Phone: (585) 442-1230 Fax: (585) 442-3827
E-mail: bkritzman@rochester.twcbc.com
Address: 1815 So. Clinton Ave. #345
Rochester, NY 14618

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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Brian M. Kritzman, DDS
1815 So. Clinton Ave., #345
Rochester, NY 14618
Phone: (585) 442-1230
Fax: (585) 442-3827

Financial Policy

We have several financial options available to work out a solution for your particular situation. We have found that our patients appreciate knowing exactly what financial responsibilities they will incur. Therefore, we inform our patients of these fees and financial arrangements in writing before treatment begins. Knowing this allows you to arrange for appropriate care. We are dedicated to providing the best possible care for you, and we want you to completely understand our payment policies.

1. So that we both have a definite understanding, please select the payment option that is most appropriate for your budget.
   1. **Accounting Reduction**
      A 5% Accounting Reduction Will Be Extended To Our Patients When Fees In Excess of $300.00 Are Paid Prior To Scheduling.

   2. **Major Credit Card**
      Visa, MasterCard, Discover, or American Express.

   3. **Extended Payment Plans**
      Extended Low Monthly Payments Based on Credit Approval..

   4. **50% in Advance Of Scheduling Treatment**
      The remaining balance is due one week prior to beginning treatment.

2. Insurance: **We are a participating provider with Excellus BC/BS and Delta Dental Premier.** We work with most insurance plans. If you are insured by a plan we do business with but not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

3. Co-Payments and Deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. For your convenience we accept MasterCard, Visa, American Express, Discover and Care Credit. You may be billed an additional co-pay due to your insurance company's policy.

4. Non-Covered Services: Be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by your insurer. You must pay for these services in full at the time of your visit.

5. Proof of Insurance: All patients must complete our patient registration form before having an exam. We must obtain a copy of your current valid insurance card to provide proof of insurance. **If you fail to provide us with the correct insurance information in the time to meet your insurance company claim filing limit, you will be responsible for the balance of the claim.**

6. Claim Submission: We will submit your claims and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. Coverage Changes: If your insurance changes, please notify us so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 30 days, the balance will automatically be billed to you.

8. Non-payment: If your account is past due, you will receive an invoice stating that payment in full is due upon receipt. Partial payments will not be accepted. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative care.

Our practice is committed to providing the best treatment to our patients. Our fees are representative of the usual and customary charges for our area. Let us know if you have any questions or concerns.

I understand the doctor may discover other or different conditions that may require additional or different procedures from those planned. I authorize such other procedures as are deemed necessary in my doctor's professional judgment to complete my treatment. The fee will be adjusted accordingly.

I have read and understand the payment policies. I acknowledge that I am financially responsible for the services provided regardless of insurance coverage.

_____

Signature of patient (or responsible party, if minor) Date