GLADSTEIN DENTAL CENTER, LLC
Eric L. Gladstein, D.M.D., M.A.G.D.
70 Vine Street
New Britain, CT 06052

MEDICAL HISTORY

Our office policy: We will treat our patients as we would like to be treated and provide them with high quality health care at a reasonable fee. We will be as gentle as possible, thorough, conscientious, and honest. We will explain your problems, our recommendations for treatment, and the estimated cost. We will be happy to answer any of your questions regarding your treatment, or your bill. Complete and accurate answers to the following questions will aid us significantly in serving you in the best possible manner.

TODAY'S DATE _____ REFERRED BY _____

Patient's Name:_____ *circle one:* Mr. Mrs. Miss. Ms. Dr. Atty. *Sex*_____

DATE OF BIRTH_____ HEIGHT_____ WEIGHT_____

SOCIAL SECURITY NUMBER_____ E-MAIL_____
DRIVER'S LICENSE NUMBER & STATE_____ **Receptionist to photo copy license/ID**

Patient's Address_____
STREET CITY STATE ZIP

HOME PHONE_____BUSINESS PHONE_____CELL PHONE_____
Employed By_____Business Address_____

PLEASE CIRCLE ONE: Single, married, divorced, separated, widowed

Spouse's Name_____Social Security No._____D.O.B.___
Employed By_____Address_____
Emergency Contact_____ Relationship_____
Home Phone_____Cell Phone_____Work Phone_____

****DENTAL INSURANCE INFORMATION******
Primary insurance company_____
Secondary insurance company_____
*****Please give copy of medical and dental insurance cards to receptionist to copy***

EMERGENCY CONTACT NAME_____Relationship_____
Home phone_____Work phone_____Cell phone_____

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT:
Name _____Address_____
Reason for visit_____Date of last dental exam_____
Previous Major Dental Treatment_____Previous Dentist_____

PLEASE PLACE AN X IF YOU HAVE OR HAD THE FOLLOWING:

___any dental pain
___teeth sensitive to hot cold,or pressure
___clenching or grinding
___bad previous dental experience
___oral habits,nail biting
___swelling of lips or mouth
___noises around ear when eating
___bad breath
___bad taste
___bleeding gums
___blisters
___wisdom teeth extracted
___orthodontics
___periodontal treatment
___root canal treatment
___complications from previous dental work
___pain around ear

PLEASE INDICATE
frequency of brushing_____
frequency of flossing _____
USE OF:
frequency of mouthwash_____
brand of mouthwash_____
other dental care products:_____
_____

OTHER: _____

over

MEDICAL HISTORY Page 2

Primary Care Physician's:_____ City_____
Specialty Care Physician:_____ City_____
Other Health Care Providers:_____ City_____
List all medications_____
_____
_____
_____

Please list all hospitalizations and approximate dates:_____
_____

PLEASE **CIRCLE** IF YOU HAVE OR HAD ANY OF THE FOLLOWING PROBLEMS

Allergies	heart	breathing
Drug reactions	stroke	asthma
Anemia	heart murmur	lung
Diabetes	heart valve	tumor, cancer
Epilepsy, seizures	prosthetic joint	radiation treatment
Kidney	blood problems	psychiatric
Liver, hepatitis	bleeding	emotional
Venereal disease	high blood pressure	neurological
Herpes	low blood pressure	hormone
Aids/HIV	rheumatic fever	thyroid
Ulcers	sinus	glaucoma
Arthritis	tuberculosis	OTHER_____
knee replacement	hip replacement	marijuana use_____
high cholesterol	C-pap machine	recreational drugs

Do you use tobacco: yes / no Type _____ Amount _____ How many years_____
Are you vaping, juuling, or using e-cigarettes: yes / no Type_____Amount_____How many years_____
Amount of alcoholic beverages consumed in a week (including beer)_____
Do you take any sexual enhancement drugs, such as Viagra, or Cialis: yes / no Type:_____
WOMEN Are you using birth control medication : yes / no If yes what type:_____
Are you pregnant_____What month_____Are you nursing_____

FEES: Are set based upon the type and complexity of the treatment. If any insurance coverage is less than we estimate, you are still responsible for the entire fee.
PAYMENTS: Patients are responsible for payment at the time of treatment. If you have insurance, we will estimate the amount of coverage. Any remaining balance will be applied to your credit card or debit card. If you are set up on a payment plan and do not keep your scheduled payments, the amount will be applied to your credit card or debit card.

I _____authorize any unpaid balance on my account to be applied to my credit card or debit card. ***Please enter BOTH credit card and debit card.***

Credit Card #_____Exp date_____Three digit code on back of card_____
***Please circle*: mastercard visa Signature_____**

Debit Card #_____Exp date_____ Three digit code on back of card_____
Signature_____

INTEREST AND COLLECTION: Any account not paid in full within thirty days from the date of billing, will be subject to interest at the rate of one and one half percent per month. Any costs of collection, legal fees, court costs, etc. will be borne by the patient.

APPOINTMENTS: This time is reserved for your treatment. If there is ever any reason that you cannot make your appointment time, please call us at least 24 hours in advance so that we may schedule another patient.

I understand the content of this page and the opposite side of this page. The information I have given is accurate and complete to the best of my knowledge. I agree to the terms and conditions as stated herein.

PATIENT'S SIGNATURE _____DATE_____

GLADSTEIN DENTAL CENTER, LLC
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70 Vine Street
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CONSENT
FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: xxxx-xx-_____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, answering machine messages, postcards, or letters).
Providing an alternate telephone number may allow our office to leave a message with a third party. Your signature on this Consent authorizes this office procedure.

You may request, in writing, that the dental practice release your medical records to another dental or medical provider. In such a case, you agree that a release of your medical records by us will comply with, and is authorized by your signature on this Consent.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Tammy Vierira

Telephone: 860-223-1162 Fax: 860-224-9215

Address: 70 Vine Street New Britain, CT 06052

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

PRINT NAME

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient:_____

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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)

_____
_____
_____

_____
Signature and date of office member

GLADSTEIN DENTAL CENTER, LLC
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70 Vine Street, New Britain, CT 06052

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 5-1-14 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.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, answering machine messages, postcards, or letters). The messages may include medical instructions (such as pre-medication or no eating or drinking before treatment). A message may be left with a third party at an alternate number provided by the patient.

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: Tammy Vierira
Telephone: 860-223-1162 Fax: 860-224-9215
Address: 70 Vine Street, New Britain, CT 06052
E-mail: GladsteinDentalCenter@comcast.net

File:Hipaa Notice of Privacy Practices 4-22-14