

Walter J. Leckowicz, Jr., D.M.D.
Prosthodontist
103 Market Square • Newington, CT 06111

Patient Information

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____ Phone _____

Cell Phone _____ CT Lic. # _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

Dental History

Previous Dentist _____ Date of last dental care _____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? Y N

If yes, describe _____

Are you currently under physician care? Y N If yes, describe _____

Have you ever had a blood transfusion? Y N If yes, give approximate dates _____

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check () if you have had any of the following:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease or malfunction | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Fainting | <input type="checkbox"/> Material allergies (latex, wool, metal, chemicals) | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Food allergies | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous problems | <input type="checkbox"/> Surgical implant |
| <input type="checkbox"/> Atopic (allergy prone) | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker/Heart surgery | <input type="checkbox"/> Swelling of feet or ankles |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Thyroid disease or malfunction |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Rapid weight gain or loss | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Cancer | Describe _____ | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Hemophilia/Abnormal bleeding | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic/Scarlet fever | <input type="checkbox"/> Ulcer/Colitis |
| <input type="checkbox"/> Circulatory problems | | | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Cortisone treatments | | | |

List medications you are taking, if any:

List drug allergies, if any:

Please complete both sides.

Primary Dental Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Additional Dental Insurance

Is patient covered by additional orthodontic insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Phone _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

(DENTAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, 20____ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Alter J. Leckowicz Jr., D.M.D.

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(860) 666-1466

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____ Phone #: _____

Patient #: _____ Social Security #: _____

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 health operations.

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 health operations, of the uses and disclosures we may make of your protected health information and of other important materials 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: Nicole Phone #: (860) 666-1466

Address: 103 Market Square City: Newington, CT 06111 Fax #: (860) 666-1518

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 the Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

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: _____

REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____