Herrmann
Dental Associates

Chart #: ___________
FOR OFFICE USE ONLY

Patient Information

Patient Name: ____ Date: ___________
Last, First MI (Preferred Name)

Social Security #: _____________________ Birth Date: ___________ Gender: ______ Marital Status: _________

Phone (Home): _______________ (Cell): ________________ (Work): ______________

Email: _________________________________ Employer/Occupation: _____________________

Address: ____
Street Apartment #

____
City State Zip Code

Health Information:

Date of Last Dental Visit: _________________ Reason for this visit: ____________________________

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Addiction _________
- ☐ Allergies __________ ___________________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Illicit Drugs_________
- ☐ Kidney Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnant
  Due date:_________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tumors
- ☐ Ulcers
- ☐ Latex Allergy
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
- ☐ ____________
- ☐ ____________
- ☐ ____________
- ☐ ____________

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
  Name of Physician: ______________________________________ Phone: _____________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____
- Have you ever needed to take antibiotic prior to dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____

Medications

Are you taking any prescription or over-the-counter medications? If yes, please list all:

________________________ ________________________ ________________________
________________________ ________________________ ________________________

Pharmacy Information

Pharmacy Name: ________________________________

Address: ____

Phone: _____________________

Insurance Information

Primary:

Plan Name: _________________________ ID #_________________________

Name of Subscriber: ____________________________ Insureds Date of Birth: ________________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________________

Secondary:

Plan Name: _________________________ ID #_________________________

Name of Subscriber: ____________________________ Insureds Date of Birth: ________________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________________

Referral Information

Whom may we thank for referring you to our practice?

☐ Another patient ☐ Dental Insurance ☐ Website ☐ Other ___________________________

Name of person or office referring you to our practice____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health or personal information, I will inform the doctors and staff at the next appointment without fail.

X: ___________________________________ **Date:** ______________________

Signature of patient, parent or guardian

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FINANCIAL POLICY

1. It is our policy that all services rendered in this office are charged directly to you, the patient. If the office accepts insurance assignment, we will as a courtesy submit your claims directly to the insurance company for payment and you will only be responsible for your co-payment at the time of service. However, in the event that any part of your claim is not paid you agree that this outstanding balance will be your responsibility.
1. If for any reason your insurance policy is cancelled or changed you must inform us immediately as it is your responsibility to keep the office up to date on any changes. If we do not participate with your new insurance coverage and you have already had work done or work is in progress, it is your responsibility to pay us in full for any charges incurred
2. All co-payments are due at the time of your office visit. If unable to pay at the time of your visit an extra $25.00 service charge will be applied to your balance.
3. ALL NEW PATIENTS: First visit will consist of x-rays and examination. When possible, a cleaning will also be done. Emergency visit patients will have an x-ray taken and a diagnosis made of the condition before any work will begin.
4. All insurance assignment patients must pay their deductible and co-insurance in full. Insurance assignment patients balance may not exceed $100.00 at any time.
5. Returned checks and balances over 30 days will be subject to additional collection fees and interest charges of 1 ½% per month.
6. A charge of **$75.00** will be made for all missed ½ hour appointments and those cancelled without 24 hours notice. Missed appointments of 1 hour will be charged at **$100.00** and each additional ½ hour of scheduled appointments beyond 1 hour will be charged at a rate of **$50.00** per ½ hour. Should a broken appointment fee be charged to me, I agree to pay this fee in advance of my next scheduled appointment

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Patient or guardian SIGNATURE

HIPAA POLICY

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.

Our office manager is in charge of privacy matters at our office. You can contact them at (516) 378-3200 if you desire further information, or have any questions or concerns.

Use and disclosure of protected information.

We may use or disclose your medical information without further notice to you or specific authorization by you where:

1. required by law;
1. required for public health purposes;
2. required by law to report child abuse;
3. where required by a health oversight agency for oversight activities authorized by law such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct;
4. required by law in judicial or administrative proceedings;
5. required for law enforcement purposes by a law enforcement official;
6. required by a coroner or medical examiner;
7. permitted by a law to a funeral director;
8. permitted by law for organ donation purposes;
9. permitted by law to avert a serious threat to health or safety;
10. permitted by law and required by military authorities if you are a member of the armed forces of the United States;

You can make reasonable requests in writing for us to use alternative methods of communicating with you in a confidential manner. Space for this is provided below.

Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Obligations that we have:

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

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office and copies will be available there.

If you want to complain about violations of your privacy rights you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. Complaints should be directed to Brian Jarmolow, Managing Director at (516) 378-3200.

No retaliator action will be taken against you for any complaint you may make.

I have received a paper copy of this notice

____________________________	______________________________	________________
Signature	**Print Name**	**Date**