Clock Tower Dental Associates
Drs. Kelley and Rayhan
110 New Hyde Park Road Franklin Square, N.Y. 11010
www.clocktower-dental.com

We are complimented that you have selected us to provide dental care for you and your family.

How did you hear about our office?

☐TV-add, ☐Website, ☐ Google, ☐Facebook, ☐Instagram, ☐Other ___________________________

➢ Patient information					
Name (First, last name)		Birth Date (MM/DD/YY) ____/____/______	Social Security# ________-________-_________		Birth Gender ☐ M ☐ F
Address	Apt#	City		State	Zip
Cell Phone # (_______) ____________________	Home Phone # (________) ________________	Email address			

➢ Guarantor/Responsible Party		
Legal Name of Responsible Party (First, Middle, Last)	Phone Number	Relationship to patient

➢ Emergency contact		
Contact name	Phone number	Relationship to Patient

➢ Dental Insurance			
Primary Insurance Company Name	Policy#/Member ID# or SS#		Group number
Insured name		Insured Date of Birth _____/_____/_______ MM/ DD/ YY	Patient Relationship to Insured ◻ Self ◻ Spouse ◻ Dependent
Insurance Company Address (usually on back of insurance card)			Phone number (_____) ______________________
Secondary Insurance Company Name	Policy#/Member ID#		Group#
Insured name		Insured Date of Birth	Patient Relationship to Insured ◻ Self ◻ Spouse ◻ Dependent
Insurance Company Address (usually on back of insurance card)		_____/_____/_______ MM/DD/YY	Phone number (_____) ______________________

Do your gums bleed when you brush? ☐ Yes ☐ No

Are your teeth sensitive to heat or cold? ☐ Yes ☐ No --- Pressure ☐Yes ☐No, Sweets? ☐Yes ☐No

Do you grind or clench your teeth? ☐Yes ☐No

Do you have any fear of dental work? ☐Yes ☐No

Date of last dental visit ______/_____/_______ What was done at the time? ______________________________

Former Dentist Name ____

How would you describe your current dental problem? _____________________________________

Are you happy with your smile? ☐Yes ☐No

Would you like to discuss your smile? ☐Yes ☐No

➢ FOR WOMEN ONLY			
Are you pregnant? ☐Yes ☐No	What months?	Are you nursing? ☐Yes ☐No	Are you taking birth control pills? ☐Yes ☐No

A: Have you taken any medication or drugs during the last two years? ☐Yes ☐No

B: Have you been taken appetite suppressants – fen-phen (fenfluramine & phentermine) or dexfenfluramine or fenfluramine?

Physician's name_______________________________ Phone number (_______) ____________________

Address ____

➢ *Medical Information*
Are you having pain or discomfort at this time? ◻Yes ◻No
Have you been a patient in the hospital during the last two years? ◻Yes ◻No
Are you now taking any medication or drugs? ☐Yes ☐No If yes, please list:
<u>Are you sensitive or allergic to any medication or anesthetics?</u> ☐Yes ☐No If yes, please list: ☐ Penicillin ☐ Amoxicillin ☐ Clindamycin Other: ___

➢ Indicate which of the following you have had or have at the present. (Please mark all yes or no)					
Heart Failure	☐Yes ☐No	Artificial Joints ☐Hip ☐Knee	☐Yes ☐No	Hepatitis A (Infectious)	☐Yes ☐No
Heart Disease	☐Yes ☐No	___		Hepatitis B (Serum)	☐Yes ☐No
Heart attack	☐Yes ☐No	Kidney Trouble	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Angina Pectoris	☐Yes ☐No	Ulcers	☐Yes ☐No	A.I.D.S	☐Yes ☐No
Congenital Heart Disease	☐Yes ☐No	Diabetes	☐Yes ☐No	H.I.V. Positive	☐Yes ☐No
Heart Murmur	☐Yes ☐No	Thyroid Problem	☐Yes ☐No	Cold Sores/Fever Blisters	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	Glaucoma	☐Yes ☐No	Blood Transfusion	☐Yes ☐No
Arteriosclerosis	☐Yes ☐No	Cancer	☐Yes ☐No	Hemophilia	☐Yes ☐No
Mitral Valve Prolapse	☐Yes ☐No	Emphysema	☐Yes ☐No	Anemia	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Chronic Cough	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
Heart Pacemaker	☐Yes ☐No	Tuberculosis	☐Yes ☐No	Bruise Easily	☐Yes ☐No
Heart Surgery	☐Yes ☐No	Asthma	☐Yes ☐No	Liver Disease	☐Yes ☐No
Rheumatic Fever	☐Yes ☐No	Hay Fever	☐Yes ☐No	Yellow Jaundice	☐Yes ☐No
Arthritis	☐Yes ☐No	Allergies or Hives	☐Yes ☐No	Epilepsy or Seizures	☐Yes ☐No
Rheumatism	☐Yes ☐No	Sinus Trouble	☐Yes ☐No	Fainting or Dizzy Spells	☐Yes ☐No
Cortisone Medicine	☐Yes ☐No	Radiation Therapy	☐Yes ☐No	Nervousness	☐Yes ☐No
Drug Addiction	☐Yes ☐No	Chemotherapy	☐Yes ☐No	Tumors	☐Yes ☐No
Stroke	☐Yes ☐No	Developmentally Disabled	☐Yes ☐No		
Allergy to Latex	☐Yes ☐No	Allergy to Metal (Jewelry, etc.)	☐Yes ☐No		
Are you on a special diet? ☐Yes ☐No					
Do you have or have you had any disease, or problem not listed? ☐Yes ☐No If yes, please list:					

Consent:

- ❖The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
- ❖ I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated foe such treatment in connection with (name of patient) ___. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
- ❖ I understand that all responsibility for payment for dental services provided in this office for myself or my dependent is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.5% finance charge (18% APR) maybe added to my account, in addition to any collection charges.
- ❖ I understand that once the treatment has started, any money paid is non-refundable.
- ❖ I understand that where appropriate, credit bureau reports may be obtained.
- ❖ I understand that it is my responsibility to advise your office of any charges in the information obtained this form.
- ❖ I authorize the use of my social security number to file my dental claim.

Patient signature ___ Date___ Witness ___

Parent or Responsible Party ___ Relationship to Patient ___

FOR OFFICE USE: Reviewed by Dr. ___ Date:___

Notice of privacy practices for your protected health information

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.

Uses and Revelations

We may use or disclose your protected health information without your written consent, written authorization or oral agreement for the following purposes.

Treatment. Example: We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.
Payment. Example: We may disclose your health information to a third party, such as an insurance company, an HMO, PPO, or your employer, in order to obtain payment for services rendered to you.
Health Care Operations. Example: We can use your medical information to carry out assessment activities and internal quality improvement and for general business administration and management activities.

We may use or disclose your protected health information without your written consent, written authorization or oral agreement in the following circumstances:

- If we provide services to you while you are in prison.
- If we provide services to you in an emergency treatment situation.
- If we are required by law to provide services to you and we are not able to obtain your consent after trying to do so.
- If there are important barriers to communication and we determine, in the exercise of our professional judgment, that you intend for us to treat.
- If we must notify or assist in the notification of a relative, personal representative or other person responsible for your care, your location, general condition or death.
- If we are required by law to disclose your medical information to a public health authority that is authorized to receive the information for the purpose of preventing or controlling disease, injury or disability.
- If we are required by law to disclose your medical information to a public health authority or another government that is authorized to receive reports of child abuse or neglect.
- If we are forced to disclose your medical information to the Food and Drug Administration.
- If we are forced to disclose your medical information to your employer to assess whether you have a work-related injury or illness.
- If we are required to disclose your health information to a governmental authority authorized to receive reports of abuse, neglect or domestic violence.
- If we are required to disclose your medical information to a health oversight agency or the supervisory activities required by law.
- If we are required to disclose your health information in response to a court order or subpoena.
- If we are forced to disclose your medical information to law enforcement officials.
- If we are required to disclose your health information to a coroner, medical examiner or funeral director.

For research purposes.
If we, in good faith, believe it is necessary to use the disclosure of your health information to prevent a serious threat to the health and safety of others.

If we are authorized by law to disclose your health information to comply with the laws established to provide benefits for work-related injuries or illnesses.

WITH THE EXCEPTION OF THE CIRCUMSTANCES ABOVE, ANY USE OR DISCLOSURE OF YOUR MEDICAL INFORMATION WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. YOUR WRITTEN AUTHORIZATION MAY BE REVOKED, IN WRITING, AT ANY TIME TO THE EXTENT THAT WE HAVE SERVED OR TAKEN ACTION IN CONNECTION WITH YOUR AUTHORIZATION.

Your Rights.

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to the requested restrictions. Your request to limit the use and/or disclosure of your health information must be made in writing to our privacy official.

Right to receive Confidential Communications. You have the right to receive confidential communications concerning your health information. Your request to receive confidential communications must be made in writing to our privacy official. We will accommodate all reasonable requests by you to receive your health information at a place other than your home address or by means other than regular mail.

Right to Inspect and/or copy. You have the right to inspect and/or copy certain health information for as long as that information remains in your record. Your request to inspect and/or copy your health information must be made in writing to our privacy official.

Right to Amend. You have the right to request that we amend certain health information for as long as that information remains in your record. You request to amend your health information must be made in writing to our privacy official and you must provide a reason to support the requested amendment.

Right to Receive an Accounting. You have the right to receive an accounting of our disclosures of your health information made six (6) years prior to the date of request. We will provide you with the first (1st) accounting in any twelve- (12) month period at no charge. There will be a fee charged for any subsequent request. Your request to receive an accounting must be made in writing to our privacy official. The accounting will not include the following disclosures:

Disclosures made to carry out treatment, payment and health care operations (TPO);

Disclosures made to you;

Disclosure made in our facility directory;

Disclosures made to individuals involved with your care;

Disclosure made for national security or intelligence purposes;

Disclosures made to correctional institutions or law enforcement officials: and

Disclosures made prior to the compliance date of the HIPPA Privacy Rule.

Right to Receive Notice. You have the right to receive a paper copy of this notice, upon request.

- **Our Duties**

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

  We must abide by the term of this while it is in effect. However, we reserve the right to change the terms of this notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this notice, we will notify you in writing and provide you with a per copy of the new notice, upon request.

- **Complaints**

  You may complain to us and the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by writing to our privacy official at the address that follows. We will not take any action against you for filing a complaint.

- **How to Contacts Us**

  If you would like further information about our privacy practices, please contact

  Dr. Michael Kelley – at the following office address

  110 New Hyde Park Road, Franklin Square, N.Y. 11010

  Phone# (516) 352-1000

  Effective Date of Notice: April 1, 2003

- **Notices of Privacy Practices**

  As required by the Privacy Regulations Created as a result of Health Insurance and Accountability Act of 1996 (HIP AA)

  This notice describes how health information about you (As patient of this practice) May be use and disclosed, and how you can get access to your individually identifiable health information,

  Please review this notice carefully

A. Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your Individually Identifiable Health Information (IIHI). In conducting our business, we will create records regarding your and the treatment and services we provide to you. Law to requires us Maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect the time.

We realize these laws are complicated, but we must provide you with the following Important information;

How we may use and disclose your IIHI

Your privacy rights in your IIH

Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice we will be effective for all of your records that we many create or maintain in the future. Our practice will post a copy of our current notice in our visible location at all times, and you may request a copy of our most current notice at any time.

B. If you have any questions about this notice, please contact:
Dr. Michael F. Kelley
Clock Tower Dental Associates
110 New Hyde Park Road, Franklin Square, N.Y. 11010.
(516) 352-1000.

MULTI-SPECIALTY GROUP
At
CLOCK TOWER DENTAL ASSOCIATES, P.C.

110 New Hyde Park Road
Franklin Square, NY 11010
516-352-1000

HEALTH CARE AUTHORIZATION FORM

Patient's Name____

Patient's SS#___________________________________ Date of Birth_______________________

THE PATIENT INDETIFIED ABOVE AUTHORIZES CLOCK TOWER DENTAL ASSOCIATES P.C. TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

I give permission to CLOCK TOWER DENTAL ASSOCIATES, P.C.

To use my address and clinical records to contact me with appointment reminders, missed appointment notification, leaving voice mail, birthday cards, holiday related cards, information about treatment alternatives, marketing, using an in-office referral board, testimonials, sending newsletters, open room adjusting/ therapies/ consultation or other health related information. I understand that this office will be using and disclosing PHI to contracted third party companies to assist in activities relating to treatment, payment, and healthcare operations.

If CLOCK TOWER DENTAL ASSOCIATES, P.C. contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

OTHER; ____

____

By signing this form, you are giving CLOCK TOWER DENTAL ASSOCIATES, P.C. permission to use and disclose your protected health information in accordance with the directives listed above.

____

Sign Date

Multi-Specialty Group
at
Clock Tower Dental Associates, P.C.

Ramin Rayhan, D.D.S.
Diplomate, American Dental Implant Association

Scott A. Siegel, D.D.S., M.D., F.A.C.S., F.I.C.S
Oral and Maxillofacial Surgery, PLLC

Jacqueline Simons, D.D.S.
Orthodontist

Michael F. Kelley, D.D.S
General dentist

Richard Nejat, D.D.S
Diplomate, American Board of Periodontology

110 New Hyde Park Road. Franklin Square, NY 11010
Telephone: (516) 352-1000 Fax: (516) 352-1059
www.clocktower-dental.com

I understand that Clock Tower Dental has agreed to collect any part of their fee directly or indirectly from a second party, such as an Insurance Company or Union, that it is a courtesy and not an obligation. If the second party should cease to make payments in a reasonable and timely manner, I will be responsible for the unpaid balance. In addition, it is my responsibility to monitor my benefits for any changes or services left on my insurance while under treatment at Clock Tower Dental.

___________________________________ Signature

________________________ Date