New City DENTAL
Dr. Michael Bang

11 Medical Park Drive Suite #103
Pomona, N.Y. 10970
845-362-3400
845-362-3495
Email: Pomona103LLC@gmail.com

Registration

Patient Information

Name (Last, First):	Middle Initial	DOB:	Sex: ☐ Male ☐ Female	Social Security:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated	Street:	

Cell Phone:	Home Phone:	Work Phone:	Email:

How did you hear about us?
☐ Post Card ☐ Internet ☐ Referral ☐ Other: _____

Emergency Contact:

Name:	Number:	Relationship to patient:

Insurance Information

Do you have Dental Insurance? ☐ Yes ☐ No Do you have a Secondary Dental Insurance? ☐ Yes ☐ No

Primary Insurance		Secondary Insurance	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber	☐Self ☐ Spouse ☐ Child ☐ Other	Relationship to Subscriber	☐ Self ☐ Spouse ☐Child ☐ Other
Insurance Company		Insurance Company	
Insurance ID#		Insurance ID#	
Insurance Group		Insurance Group	
Insurance Phone#		Insurance Phone#	
Employer Name		Employer Name	
Employer Phone#		Employer Phone#	

Acknowledgement

I understand that regular (every six months) check-up (examinations, cleaning and needed x-rays) following the recommended treatment plan and making and keeping the needed appointments are vital to the maintenance of a healthy mouth.

I understand that it is the patient's responsibility to make and keep all necessary appointments and follow-up with the recommended treatment plan.

I understand that if a patient fails to comply with the recommended treatment plan and/or regular check-ups, oral conditions could deteriorate, requiring more treatment and possible tooth loss and the patient will be responsible for all risk and consequences.

Printed Name of Patient (or Patient Representative) _____

Signature of Patient (or Patient Representative) _____ Date: _____

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Health Information

We make your oral health very seriously. But before we start your treatment, we need some brief information on our medical history which may affect your treatment. All information is confidential.

Have you been under the care of a physician? ☐ Yes ☐ No	Last Physical Date	Physician's Name & Phone#
Work Related Injury? ☐ Yes ☐ No	Have you ever been hospitalized? ☐ Yes ☐ No	Reason for today's visit:
Date of last dental visit:	Date of last dental x-rays:	Date of last cleaning:
Have you ever been treated for periodontal (gum) disease? ☐ Yes ☐ No	Ever had Novocain or other local anesthetic? ☐ Yes ☐ No	Are you interested in tooth whitening? ☐ Yes ☐ No
If you are wearing dentures: Age of dentures? _____ Are you interested in new dentures? ☐ Yes ☐ No	Are you taking or have taken any steroid/cortisone therapy in the last 2 years ☐ Yes ☐ No	Are you taking or have you taken Oral Bisphosphonates? ex: Fosamax, Actonel, Boniva or IV Bisphosphonates (Zometa, Aredia) ☐ Yes ☐ No Taken how long? _____
Have you taken antibiotics prior to dental procedures in the past? ☐ Yes ☐ No	Have you ever had an adverse reaction or become ill after taking penicillin, aspirin, codeine, local anesthetics, latex, metals or any other medication? ☐ Yes ☐ No	

List any medications you are taking including non-prescription drugs and herbals/vitamins:

1._____ 2._____ 3. _____ 4._____

List any medications you are allergic to:

1._____ 2._____ 3. _____ 4._____

Do you have any history of:	Y	N		Y	N		Y	N		Y	N
Rheumatic Fever			Asthma			Thyroid Disease			Alcoholism		
Heart Murmur			Allergies or Hives			Epilepsy or Seizures			Psychiatric Treatment		
Mitral Valve Prolapse			Anemia			Fainting or Dizzy Spells			Mouth Sores/growths		
Diabetes			Teeth Grinding/Clenching			Pace Maker/Heart Surgery			Aspirin/Anticoagulant Therapy		
Venereal Disease			Arthritis			Pain in your jaw (TMJ)			Ulcers or stomach Problems		
High Blood Pressure			HIV Positive/Aids			Latex Allergy			Any type of Implant		
Low Blood Pressure			Blood Transfusion			Sinus Problems			Cancer (Type:)		
Any type of Transplant			Heart Problem ( )			Excessive Bleeding			Any Artificial Hip, Knee or other Joint)		
Drug Addiction			Dialysis			Stroke			Other Disease or Illness:		
Hepatitis (Type:)			Chemotherapy			Lung Disease					
Liver Disease			Radiation Treatment			Breathing Problems					
Kidney Disease			Use of Tobacco Products			Tuberculosis (TB)					

Women Patient Only:	Y	N		Y	N
Is there a possibility of pregnancy?			Are you nursing?		
Estimated Delivery Date:			Are you taking any birth control prescriptions?		

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to reform an examination and diagnose my condition. I also give my consent for any preventative or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patients Signature: _____ Date: _____

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Please note as of 04/01/2019 we have a 1 day cancellation policy

If you need to change or reschedule your appointment, please give us at least 1 days' notice so that we will be able to fill this time with others waiting for an appointment.

If your appointment is on a Monday, please call the office and leave us a message over the weekend.

If you cancel or fail to how for your confirmed appointment, you will be charged a $20.00 fee (updated 9/27/21) as a broken appointment.

Thank you for your cooperation!

Print Name of patient: _____

Signature of patient: _____ Date: _____

NOTICE OF PRIVACY PRACTCE

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(DENTAL)

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

The heart insurance Portability and 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 ow 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, coordination, or managing health care and related services by one or more health care provides. 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 conduction 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 reference to individually indefinable 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 require to honor and abide by that

Patient's Signature: _____ Date: _____

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PATIENT COPY

HIPAA Notice of Privacy and Confidentiality & Patient's Rights

Patients' rights under HIPA are described in the "notice of Privacy Practices".
The notice will be made available to the patients. These rights include:

1. Right to receive the "Notice of Privacy Practices", which informs patients of their rights and how to exercise them. By law this notice is to be made available to patients, and a good faith effort to obtain the patient's acknowledgement of receipt is required.

2. Right of Access. Patients may request to inspect their medical records and may request copies. There may be a fee to produce the copiers. The prices to follow and how to request copies is explained in the "Notice of Privacy Practices."

3. Right to Request and Amendment or Addendum. The Notice describes how to file a request for an amendment or addendum.

4. Right to an Accounting of Disclosures. Patients have the right to receive an accounting of disclosures of their Patient Health Information (PHI). The Notice describes how to request an accounting.

5. Right to Request Restrictions. Patients have the right to request restrictions on how they will be communicated with or how their PHI is released. Generally, every effort to try to accommodate reasonable requests for restrictions, e.g., where release of information could be harmful to the patient.

6. Rights to complain. Patients have the right to complain if they think that privacy rights have been violated. The "Notice of Privacy Practices" describes where to file a complaint.

Exceptions to the Rules

Under HIPAA, there are certain exceptions to these general rules. These exceptions are described in the "Notice of Privacy Practices. " Disclosures can be made without patient authorizations: subject to professional judgement, for public health and safety purposes, for government functions, law enforcement, and abased on a judicial request or subpoena.