

**Dentistry by Dr. Kaplansky, PLLC**

Family Dentistry & Braces

www.DrKaplansky.com

**MEDICAL HISTORY**

Name (Last) (First) (Middle) / / M F S M D W Date of Birth Sex Marital Status Social Security Number

Home Address (Street) (City) (State) (Zip Code) Home Phone Number

Dental Insurance Co. Name of insured DOB of insured Insurance ID/ SS#

Employer Occupation Cell Phone Email address

Business Address (Street) (City) (State) (Zip Code) Business Phone Number

General health (please check): EXCELLENT  GOOD  FAIR  POOR  Name of physician \_\_\_\_\_

Physician's address \_\_\_\_\_ telephone number \_\_\_\_\_ date of last physical \_\_\_\_\_

Are you pregnant? ..... Yes  No . If yes, expected delivery date: \_\_\_\_\_

Do you smoke? ..... Yes  No . If yes, how much? \_\_\_\_\_

Are you allergic to any medications? ..... Yes  No . If yes, names of medications \_\_\_\_\_

Are you taking any medication now? ..... Yes  No . If yes, names of medications and problems for which they are taken:

Medications \_\_\_\_\_

Have you ever had (please check-mark appropriate boxes):

- Heart disease..... Yes  No  Cancer ..... Yes  No
- Rheumatic fever..... Yes  No  Mitral valve prolapse ..... Yes  No
- Abnormal blood pressure ..... High  Low  No  Night sweats ..... Yes  No
- Ulcers..... Yes  No  Heart murmur ..... Yes  No
- Tuberculosis or lung disease..... Yes  No  Jaundice ..... Yes  No
- Diabetes..... Yes  No  Drastic weight loss ..... Yes  No
- Epilepsy ..... Yes  No  Asthma or hay fever ..... Yes  No
- Anemia..... Yes  No  Sinus trouble ..... Yes  No
- Congenital heart lesions ..... Yes  No  Hepatitis ..... Yes  No
- Arthritis..... Yes  No  X-ray treatments for cancer..... Yes  No
- Lymph node enlargement (swollen glands)..... Yes  No  Glaucoma ..... Yes  No
- Common cold..... Yes  No  Persistent diarrhea ..... Yes  No
- AIDS..... Yes  No  Stroke ..... Yes  No
- Prolonged bleeding..... Yes  No  Fainting spells ..... Yes  No
- Excessive urination and/or thirst..... Yes  No  Swollen ankles ..... Yes  No

If you have entered "yes" to any of the above, please explain: \_\_\_\_\_

How did you hear about Dr. Kaplansky? \_\_\_\_\_

Patient: \_\_\_\_\_

Sign name

\_\_\_\_\_

Date

Relationship to patient \_\_\_\_\_ if patient is LESS THAN 18 YEARS OLD, parent or legal guardian MUST sign above

## DENTAL HEALTH and APPEARANCE

Reason for visit: \_\_\_\_\_ Approximate date of last dental visit: \_\_\_\_\_

What is your *primary* concern that you would like us to address first? \_\_\_\_\_

When would you like us to start treatment? \_\_\_\_\_

Have you ever had any serious problem associated with previous dental treatment? ..... Yes  No

Is "yes", please explain: \_\_\_\_\_

What, if anything, has happened in previous experiences at the dentist, that was reason not to return? \_\_\_\_\_

\_\_\_\_\_

Do you have missing teeth? \_\_\_\_ If yes, have you had them replaced? \_\_\_\_

If you *have* had missing teeth replaced, are you happy with the results? \_\_\_\_\_

If not, would you like to learn about your options to replace them? \_\_\_\_\_

Do you ever feel (or have you ever been told) that you don't have fresh breath? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_ How often do you floss (routinely)? \_\_\_\_ What type of brush do you use? SOFT  MED  HARD

Do you avoid brushing any part of your mouth because of pain? Yes  No . If yes, what part? \_\_\_\_\_

Which foods cause you twinges of pain: hot  cold  sweet  sour  none  Do you lose fillings or break fillings? Yes  No

Do you chew on only one side of your mouth? ..... Yes  No  If yes, explain: \_\_\_\_\_

Do your gums bleed, feel tender or swollen? ..... Yes  No  Do you usually have many cavities? ... Yes  No

Do you clench or grind your jaws while sleeping or during the day? ..... Yes  No  Do your jaws ever feel tired? ..... Yes  No

We respect your right to *choose* the level of care that fits *your* needs. We've found that many adults are unaware that problems even exist. There are *rarely* symptoms (pain, bleeding) associated with the aging and deterioration of teeth and gums – *until* it is far too late. According to the American Dental Association, more than 80% of American adults have some level of gum disease. With your permission we would like to explain the *choices* available to achieve long-term health and beauty for your existing natural teeth. Please check **all** that apply:

- I desire to keep my own teeth for life, if possible. I want my teeth to look good, feel good, and *last* for a long time
- Spreading payments out over time may help me to achieve the excellent results I desire
- Phasing treatment, by priority, over a few years may make it feasible for me to achieve the excellent results I desire
- I *am* interested in a plan for long-term dental health. However, I am currently unable to pursue this, and would appreciate help with emergencies and cleanings for now
- Although I am not interested in a plan for long-term dental health, I *do* desire an office who will treat teeth in need of immediate/emergency attention, as well as keep me up to date on cleanings.

## COSMETIC/ESTHETIC EVALUATION

Are you happy with your smile? \_\_\_\_\_ Please *rate* your smile from 1 to 10 (1= I hate my smile, 10= awesome) \_\_\_\_\_

Would you like to have whiter teeth?  Yes  No

If you had a *magic wand* what, if anything, would you change about your smile? \_\_\_\_\_

Do you have any *special* occasions coming up? \_\_\_\_\_

Please add anything you feel is important: \_\_\_\_\_

\_\_\_\_\_

## **URGENT MEDICAL HISTORY UPDATE**

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Patient's name

Date

Please, let us know if you currently take or have taken in the past (either orally or through IV) any of the following drugs, they are often prescribed for Osteoporosis, Cancer, or Paget's disease: (circle the answer)

Actonel (Risedronate)

Aredia (Pamidronate)

Bonefos (Clondronate)

Boniva (Ibandronate)

YES

NO

Didronel(Etidronate)

Fosamax (Alendronate)

Ostac (Clondronate)

Skelid (Tiludronate)

Zometa (Zoledronic Acid)

Having been treated previously with Bisphosphonate drugs you should know that there is a significant risk of future complications associated with dental treatment.

Bisphosphonate drugs appear to adversely affect the ability of bone to break down or remodel itself thereby reducing or eliminating its ordinary excellent healing capacity.

This risk is increased after surgery, especially from extraction; implant placement or other "invasive " procedures that might cause even mild trauma to bone. Osteonecrosis may result. This is a smoldering, long-term, destructive process in the jawbone that is often very difficult or impossible to eliminate.



## ***Financial Information***

*Payment for services is ultimately the responsibility of the patient/guardian. Your dental plan is designed to share in your dental care costs. It rarely covers the total cost of your treatment.*

### **Patients with Insurance:**

Patients with insurance are required to pay their copay and deductible at the time services are rendered. We will make our best effort to properly calculate your copay. If we overestimate your copay, the excess will be refunded to you. If we underestimate your copay, the amount will be billed to you. As a courtesy we will process your insurance claim.

*Children under 14 must be accompanied to their appointments by a parent/guardian. Minors 14 and over who come to appointments on their own must be prepared to pay the appropriate amount. If a patient does not have payment, we will not be able to treat them that day. In the case of minor children, the parent or legal guardian authorizing treatment for the child is financially responsible to this office, regardless of any separation, divorce or court agreements. We are not a party to these agreements.*

**NOTE:** If a particular service is not covered fully, you will be responsible for the remainder of the fee. If a particular service is not covered at all, you will be responsible for the full fee. For portions not covered by insurance, you may choose from the options below.

1. Prepayment in full prior to the start of treatment with 5% courtesy discount.
2. Payment in full at the time of service with cash, check, MC, VISA, DISCOVER, AMERICAN EXPRESS.
3. CARE CREDIT: Interest free plans are available to those who qualify. Several low-interest plans are also available for extensive treatment plans.

### **Unpaid balances:**

Balances over 30 days will be assessed a 1.5% monthly late charge (18% APR). All outstanding balances over 90 days will be subject to collection by an outside agency, which may adversely affect your credit rating. Your personal financial information will be disclosed to a third party. You will be responsible for ALL collection and attorneys fees incurred by us as a result.

### **Cancellations:**

*The appointment made is reserved especially for you. We require a minimum of 24 hours notice for cancelled appointments. There will be a \$50 charge for missed appointments. If you miss an appointment that is an hour or longer, you will be asked to make a deposit equal to the total cost of the visit for future appointments. Patients who repeatedly cancel appointments without notice will be asked to seek care elsewhere.*

### **Returned Checks:**

A fee of \$35 will be assessed for returned checks to cover insufficient funds bank fees.

I have read the above financial and cancellation policies and agree to abide by them. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

A COPY OF THIS AGREEMENT WILL BE PROVIDED UPON REQUEST.

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

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\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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### For Office Use Only

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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)

# NOTICE OF PRIVACY PRACTICES

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**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.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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## **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (03/01/2003), 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

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## **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make

reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**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 of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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## **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.50 for each page, \$10 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**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.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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**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 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.

Contact Officer: Dr. Igor Kaplansky\_\_\_\_\_

Telephone: 716-772-7500\_\_\_\_\_ Fax: 716-772-7533\_\_\_\_\_

E-mail: \_\_\_\_\_

Address: 8038 Rochester Rd. Gasport, NY 14067\_\_\_\_\_