KINGS HIGHWAY ORAL & MAXILLOFACIAL SURGERY
1610 East 19th St ● Brooklyn ● NY ● 11229
718.576.6999

NEW PATIENT REGISTRATION

PATIENT INFO:

LAST NAME: _____ FIRST NAME: _____ DATE: ____ / ____ / _____

DOB: ____/____/____ AGE: _____ SEX: ☐M ☐F SOCIAL SECURITY: _____
M D YR

ADDRESS: _____
APT # CITY STATE ZIP

HOME TEL: (__)_____-_____ CELL: (__)_____-_____ E-mail: _____@_____

EMERGENCY CONTACT NAME: _____ CELL: (___)_____-_____

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed EMPLOYMENT STATUS: ☐FT ☐PT
Employer_____ Occupation_____

STUDENT: ☐YES ☐NO IF YES: SCHOOL: _____ ☐FT ☐PT

Who May We Thank for Referring You to our Office? _____
Were you referred to us by: **GOOGLE** **YELP** (Please Circle)

Who Is your General Dentist? _____ **Contact Info**:_____

PHARMACY INFORMATION NYS is now mandatory E-scribe

Pharmacy Name_____ Address_____
Pharmacy Number:_____

IF YOU ARE COVERED BY MORE THAN 1 DENTAL OR MEDICAL INSURANCE PLAN (E.G. THROUGH BOTH OF YOUR PARENTS OR 1 FROM YOUR EMPLOYER AND 1 FROM YOUR SPOUSE'S EMPLOYER) PLEASE ASK THE RECEPTIONIST FOR AN ADDITIONAL FORM. TELLING US ABOUT SECONDARY COVERAGE IS VERY IMPORTANT BECAUSE IT MIGHT SUBSTANTIALLY LOWER YOUR CO-PAYMENT AMOUNT.

PRIMARY DENTAL INSURANCE INFORMATION:

INSURANCE:_____ Name of Policy Holder:_____ DOB ____/____/_____

Relationship of patient: ☐Self ☐Spouse ☐Parent ☐Other Policy Hldr SSN:_____ INSURANCE ID#: _____

Address (if different than patient's):_____

PRIMARY MEDICAL INSURANCE INFORMATION:

INSURANCE:_____ Name of Policy Holder:_____ DOB ____/____/_____

Relationship of patient: ☐Self ☐Spouse ☐Parent ☐Other Policy Hldr SSN:_____ INSURANCE ID#: _____

Address (if different than patient's):_____

ASSIGNMENT OF BENEFITS

I hereby authorize payment of dental or medical benefits to KINGS HIGHWAY ORAL & MAXILLOFACIAL SURGERY for the services provided. I give my permission to the doctor to submit insurance benefit claim forms in my name and on the behalf of myself, my spouse and/or my minor children**. I realize that I am responsible for and agree to pay any charges not covered by my insurance**. This includes unmet deductibles, non-covered services, etc.

If I allow my account to become delinquent and it is referred to a collection agency or attorney, I am SOLELY responsible for any outstanding balances and ALL reasonable collection costs and attorney's fees.

SIGNATURE OF PATIENT, PARENT OR GUARANTOR: _____ DATE: ___/___/_____

KINGS HIGHWAY ORAL & MAXILLOFACIAL SURGERY

PATIENT MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Have you ever been hospitalized or had a major operation? □ Yes □ No If yes, please explain:
_____

Have you ever had a serious head or neck injury? □ Yes □ No If yes, please explain:
_____

Are you taking any medications, pills, or drugs? □ Yes □ No If yes, please explain:
_____

Are you on a special diet? □ Yes □ No If yes, please explain:
_____

Do you use controlled substances? □ Yes □ No If yes, please explain:
_____

Do you use tobacco? □ Yes □ No

Women: Are you
Pregnant/Trying to get pregnant? □ Yes □ No Taking Oral Contraceptives? □ Yes □ No Nursing? □ Yes □ No

Are you taking any blood thinners?

O Advil O Aggrenox O Aspirin O Clopidogrel/Plavix O Coumadin/Warfarin O Pradaxa O Eliquis
O NSAIDS O Xarelto O Effient/Prasugrel O Other _____
If yes Pleas explain: _____

Are you ALLERGIC to any of the following?
□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics
□ Azithromycin □ NONE □ OTHER If yes, please explain:_____

Do you have, or have you had any of the following?

□ AIDS/HIV Positive	□ Cortisone Medicine	□ Heart Trouble/Disease	□ Recent Weight Loss
□ Alzheimer's Disease	□ Diabetes	□ Hemophilia	□ Renal Dialysis
□ Anaphylaxis	□ Drug Addiction	□ Hepatitis A	□ Rheumatic Fever
□ Anemia	□ Easily Winded	□ Hepatitis B or C	□ Scarlet Fever
□ Angina	□ Emphysema	□ Herpes	□ Shingles
□ Arthritis/Gout	□ Epilepsy or Seizures	□ High Blood Pressure	□ Sickle Cell Disease
□ Artificial Heart Valve	□ Excessive Bleeding	□ Hives or Rash	□ Sinus Trouble
□ Artificial Joint	□ Excessive Thirst	□ Hypoglycemia	□ Spina Bifida
□ Asthma	□ Fainting Spells/Dizziness	□ Irregular Heartbeat	□ Stomach/Intestinal
□ Blood Disease	□ Frequent Cough	□ Kidney Problems	□ Stroke
□ Blood Transfusion	□ Frequent Diarrhea	□ Leukemia	□ Swelling of Limbs
□ Breathing Problem	□ Frequent Headaches	□ Liver Disease	□ Thyroid Disease
□ Bruise Easily	□ Genital Herpes	□ Low Blood Pressure	□ Tonsillitis
□ Cancer	□ Glaucoma	□ Lung Disease	□ Tuberculosis
□ Chemotherapy	□ Hay Fever	□ Mitral Valve Prolapse	□ Tumors or Growths
□ Chest Pains	□ Heart Disease, CAD	□ Pain in Joints	□ Ulcers
□ Cold Sores/Fever Blisters	□ Heart Attack/Failure	□ Parathyroid Disease	□ Venereal Disease
□ Congenital Heart Disorder	□ Heart Murmur	□ Psychiatric Care	□ Yellow Jaundice
□ Convulsions	□ Heart Pace Maker	□ Radiation Treatments	

Have you ever had any serious illness not listed above? □ Yes □ No If yes, please explain:
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.
NAME _____
SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ **DATE** _____
Relationship to the Patient: 0 SELF 0 PARENT 0 LEGAL GUARDIAN 0 OTHER

KINGS HIGHWAY
ORAL & MAXILLOFACIAL SURGERY

FINANCIAL POLICY

We would like to take this opportunity to extend a personal "Thank you" for allowing us to assist with your oral surgery needs. Dr. Saar Amrani and the team at Kings Highway Oral & Maxillofacial Surgery are committed to providing you with the highest quality of surgical care, as your health and well-being are our primary concern. Please understand that prompt payment of expenses is part of your treatment. Thus, the following is a statement of our Financial Policy, which we require you read and sign prior to any treatment. We are happy to provide you with a signed copy for your records.

PAYMENT OPTIONS

Full payment is due at the time of service unless prior arrangements have been made.
If you have insurance, deductible and co-payments are due at the time of service.

We accept: CASH, CREDIT CARDS, or CARE CREDIT

INSURANCE

We understand that the financial aspects of healthcare can be difficult to understand and confusing. Our office will try to do everything we can to help you. If you provide us accurate and current insurance information, we will be happy to file your charges with your primary and secondary insurance companies. Because insurance policies vary greatly, we can estimate your coverage in good faith, but cannot guarantee it. Please keep in mind that your insurance policy is a contract between you and your insurance company. In the event your account is placed with an agency for collection purposes, you will be responsible for all collection agency fees (up to 30% of the balance placed for collection). In addition, you will be responsible for all court costs, filing fees, and attorney fees should your account require litigation.

MEDICAL OR DENTAL DEDUCTIBLE

A deductible on a Medical or Dental policy is the fee you agree to pay annually in the event you receive treatment. It usually starts anywhere between $25 and $3,000. How does it work? After you treat up to the value of your deductible, your benefits kick-in. So, for example, if you have a $100 deductible and your first visit for the benefit year costs $150, you will owe $100 of the bill. Your insurance company will owe the remaining $50. Then, the next bill will be covered based on your specific benefits. The good news is that since deductibles are annual, you only have to pay them once.

APPOINTMENT POLICY

48 hours notice is required for canceled appointments. Missed appointments and canceled appointments with less than **48 hours** notice will be assessed a $50.00 fee, payable immediately. We understand that conflicts occur, but the more notice given, the better chance we have to appoint another patient in need of dental care. We ask that you respect our schedule as we do yours by seeing our patients in a timely manner.

CARE CREDIT

As a service to our patients, we are pleased to offer the CareCredit card, North America's leading patient payment program. CareCredit lets you begin your treatment immediately then pay for it over time with low monthly payments that are easy to fit into your monthly budget. CareCredit is an excellent option with no interest payment plans available up to 12 months. If you are interested in learning more about this option please check this box: □

I understand and agree to this financial policy: _____ _____
Signature of patient or responsible party Date

NOTICE OF PRIVACY PRACTICES

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 an examination or oral surgery.
- 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 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 and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

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 November 1, 2011 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 a formal, written complaint with us, or with the Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, S.W. Washington, D.C. 20201 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.

Name:_____ Signature: _____ Date: _____