Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name_____ Soc. Sec. #_____
Last Name *First Name* *Initial*

Address_____ City_____ State_____ Zip_____

Email_____ Home Phone_____ Cell Phone_____

Preferred method of contact for appointment reminders: ☐ Home Phone ☐ Cell Phone (text)** ☐ Email **

Sex ☐ M ☐ F Age_____ Birth date_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Business Email_____ Whom may we thank for referring you?_____

Notify in case of emergency_____ Home Phone_____

Cell Phone _____ Business Phone_____ Email_____

Primary Insurance

Person Responsible for Account_____
Last Name *First Name* *Initial*

Relation to Patient_____ Birth date_____ Soc. Sec. #_____

Address (if different from patient)_____ Home Phone_____

City_____ State_____ Zip_____ Cell Phone_____

Email_____ Person Responsible Employed by_____

Occupation_____ Business Address_____

Business Phone_____ Business Email_____

Insurance Company_____ Phone_____

Contract #_____ Group #_____ Subscriber #_____

Name of other dependents under this plan_____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name_____ Relation to Patient_____ Birth date_____

Address (if different from patient)_____ Soc. Sec. #_____

City_____ State_____ Zip_____ Home Phone_____

Cell Phone_____ Email_____

Subscriber employed by_____ Business Phone_____

Business Email_____

Insurance Company_____ Phone_____

Contract #_____ Group #_____ Subscriber #_____

Name of other dependents under this plan_____

- Please complete other side -

Dental History

What would you like us to do today?_____Are you in dental discomfort today?_____

Former Dentist_____ Address_____

Dentist's Email_____Phone_____

Date of last dental care_____ Date of last x-rays_____

Check (✓) yes or no if you have had problems with any of the following:

☐ Y ☐ N Bad breath	☐ Y ☐ N Food collection between teeth	☐ Y ☐ N Periodontal treatment	☐ Y ☐ N Sensitivity to sweets
☐ Y ☐ N Bleeding gums	☐ Y ☐ N Grinding or clenching teeth	☐ Y ☐ N Sensitivity to cold	☐ Y ☐ N Sensitivity when biting
☐ Y ☐ N Clicking or popping jaw	☐ Y ☐ N Loose teeth or broken fillings	☐ Y ☐ N Sensitivity to hot	☐ Y ☐ N Sores or growths in mouth

How often do you brush?_____ Floss?_____

How do you feel about the appearance of your teeth?_____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Y ☐ N

Other information about your dental health or previous treatment_____

Medical History

Physician's name:_____ Phone_____ Date of last visit_____

Have you had any serious illnesses or operations? ☐ Y ☐ N

If yes, describe_____

Are you currently under physician care? ☐ Y ☐ N If yes, describe_____

Have you ever bad a blood transfusion? ☐ Y ☐ N If yes. give approximate dates_____

Have you ever taken Fen-Phen/Redux? ☐ Y ☐ N

Women: Are you pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Taking birth control pills? ☐ Y ☐ N

Check (✓) yes or no whether you have had any of the following:

☐ Y ☐ N AIDS/HIV Positive	☐ Y ☐ N Cough, persistent	☐ Y ☐ N Jaw Pain	☐ Y ☐ N Shingles
☐ Y ☐ N Anaphylaxis	☐ Y ☐ N Cough up blood	☐ Y ☐ N Kidney disease or malfunction	☐ Y ☐ N Shortness of breath
☐ Y ☐ N Anemia	☐ Y ☐ N Diabetes		☐ Y ☐ N Skin rash
☐ Y ☐ N Arthritis, Rheumatism	☐ Y ☐ N Epilepsy	☐ Y ☐ N Liver disease	☐ Y ☐ N Spina Bifida
☐ Y ☐ N Artificial heart valves	☐ Y ☐ N Fainting	☐ Y ☐ N Material allergies	☐ Y ☐ N Stroke
☐ Y ☐ N Artificial joints	☐ Y ☐ N Food allergies	(**latex**, wool, metal. chemicals)	☐ Y ☐ N Surgical implant
☐ Y ☐ N Asthma	☐ Y ☐ N Glaucoma	☐ Y ☐ N Mitral valve prolapse	☐ Y ☐ N Swelling of feel or ankles
☐ Y ☐ N Atopic (allergy prone)	☐ Y ☐ N Headaches	☐ Y ☐ N Nervous problems	☐ Y ☐ N Thyroid disease or malfunction
☐ Y ☐ N Back problems	☐ Y ☐ N Heart Murmur	☐ Y ☐ N Pacemaker/ Heart surgery	☐ Y ☐ N Tobacco habit
☐ Y ☐ N Blood disease	☐ Y ☐ N Heart problems		☐ Y ☐ N Tonsillitis
☐ Y ☐ N Cancer	Describe_____	☐ Y ☐ N Psychiatric care	☐ Y ☐ N Tuberculosis
☐ Y ☐ N Chemical dependency	☐ Y ☐ N Hemophilia/	☐ Y ☐ N Rapid weight gain or loss	☐ Y ☐ N Radiation treatment
☐ Y ☐ N Chemotherapy	☐ Y ☐ N Herpes		☐ Y ☐ N Hepatitis
☐ Y ☐ N Ulcer/Colitis	☐ Y ☐ N Circulatory problems	☐ Y ☐ N Respiratory disease	☐ Y ☐ N Rheumatic/Scarlet fever
☐ Y ☐ N Venereal disease	☐ Y ☐ N Cortisone treatments	☐ Y ☐ N High blood pressure	

Is patient currently taking any medications? If yes. list all:_____

Does patient have drug allergies? If yes. list all:_____

Authorization & Financial Policy

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge I understand that this information will be used by Dr. Mancuso to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform Dr. Mancuso.

I authorize the insurance company indicated on this form to pay Dr. Mancuso all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Dr. Mancuso to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not they are paid by my insurance provider.

I understand and agree that payment must be made in full at time of treatment, or by the due date on my statement. If payment is not received by that date, I will be charged a late fee of $25.00 ____ (initial), plus interest charges of 1 1/2% per month, 18% per annum ____ (initial). In the event of non-payment, I agree to be responsible for all costs of collections, including attorney fees and court costs. ____ (initial).

**Caution: If you elected to communicate with our office electronically; there is some level of risk that third parties may be able to read unencrypted messages which could expose your identity and personal health information.

Signature_____ Date_____

MARY T. MANCUSO, DMD, PA
27-11 Pellack Drive | Fair Lawn NJ 07410 | 201-796-7171

PAYMENT AGREEMENT FOR PATIENTS WITHOUT DENTAL INSURANCE

Thank you for choosing our office as your dental healthcare provider. The following guidelines explain our Financial Policy which requires your approval prior to receiving treatment.

1. At the onset of treatment, we will provide you an estimate for the cost of treatment. Should the need for additional treatment arise during the course of treatment, you will be notified for your approval prior to proceeding with additional treatment.

2. Payment is due in full at time services are rendered. We accept checks, credit cards, cash, and Care Credit. Payment options are as follows:

   Option A: Patients who pay in full with a check or cash, on or before the start of treatment (fees over $1,000), will receive a courtesy discount of (5%).

   Option B: Patients who pay in full with Visa, MasterCard, Discover, or American Express on or before the start of treatment (fees over $1,000), will receive a courtesy discount of (2%).

   Option C: Patients with a proven credit history and with treatment over $1,000 may pay with interest-free installments. A 50% deposit is due on or before the start of treatment, and the balance can be spread equally over 2 or 3 months.

   Option D: Patients who are to receive treatment that requires dental laboratory work, such as dentures, crowns, bridges, retainers, mouth-guards, etc., are required to pay a 50% deposit on or before the start of treatment, and pay the remaining balance at when the prosthesis is cemented or inserted.

   Option E: Patients looking for extended monthly payment options choose to partner with Care Credit. Please talk to our Patient Coordinator for plan options and/or application information.

   Option F: We offer an In-House Dental Program, making dental care more affordable for patients without dental insurance. Please talk to our Patient Coordinator for plan options and/or application information.

3. The parent or guardian that accompanies a minor child or children to their dental appointment is the party responsible for payment due. Unaccompanied minors with non-emergency treatment will be denied unless the fees have been pre-authorized prior to the appointment date.

4. Checks returned to our office unpaid will be subject to a fee of $35.00.

5. We understand that sometimes it is necessary to change an appointment, so we ask that you give us at least 2 business days notice. Patients who continually break appointments may be dismissed from our practice.

6. In the event payment is not received by its due date, the total balance will become due immediately, and the account will be subject to monthly late fees of $25.00 and interest of 1-1/2% per month (18% per year). _____ (initial). In the event of non-payment, the patient will be responsible for all costs of collections (approx. 40%), including reasonable attorney fees and court costs. _____ (initial).

AGREEMENT TO THIS FINANCIAL POLICY

I, _____ have read and agree to this Financial Policy on _____.
(Name) (Date)

_____
(Signature)

Mary T. Mancuso, DMD, PA

Notice of Privacy Practices

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 6/28/2016, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a

person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

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

requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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 Our Privacy Official:

Paul Englander
27-11 Pellack Drive | Fair Lawn NJ 07410
Telephone: 201-796-7171 | Fax: 201-796-0600
Email: admin@drmarymancuso.com

MARY T. MANCUSO, DMD PA

27-11 Pellack Dr Fair Lawn NJ 07410 info@DrMaryMancuso.com

NOTICE OF PRIVACY PRACTICES
RECEIPT OF ACKNOWLEDGEMENT

HIPAA requires dentists to deliver a Notice of Privacy Practices statement to all their patients. You may download our statement from our website (under "New Patient Documents"), receive a physical paper copy, or have a PDF copy sent to your email or mobile number. Please indicate how you would like to receive your notice. Please select ONE from the following:

- **I Will Download it From Your Website** ☐
- **Please Send Me a Paper Copy** ☐
- **Please Email a Copy** ☐ Email Address: _____
- **Please Text me a Copy** ☐ Mobile Phone Number: _____ Provider _____

I, _____ have received a copy of the NOTICE OF PRIVACY PRACTICES of this office. I am aware that additional copies are available to me anytime at my request. Please Note: It is your right to refuse to sign this acknowledgement.

Patient's Signature: _____ Date: _____

THIS SECTION IS FOR OFFICE USE ONLY-

We tried to obtain written acknowledgement by the individual noted above of receipt of our NOTICE OF PRIVACY PRACTICES, but it could not be obtained because:

- ☐ An emergency prevented us from obtaining acknowledgement.
- ☐ A communication barrier prevented us from obtaining acknowledgement.
- ☐ The individual was unwilling to sign.
- ☐ Other:

_____

_____

_____

_____

Employee's Name: _____Date:_____