Fraiman Prosthodontics

Patient Information

Patient Name _____ Birthdate _____ Home Phone ( )_____
Address _____ City _____ State _____ Zip _____

Sex __M __F __Married __Widowed __Single __Minor __Separated __Divorced __Partnered

Email_____ Cell Phone ( ) _____
Employer/School _____ Employer/School Phone ( ) _____
Employer/School Address _____City _____State_____ Zip_____
Spouse or Parent's Name _____Employer _____Work Phone ( ) _____

Responsible Party Information

Name of Responsible Party _____Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Social Security # _____ Birthdate _____
Phone (Home) _____ Phone (Work) _____

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone ( ) _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State _____ Zip _____

Secondary Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone ( ) _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State _____ Zip _____

Authorization And Release

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have any change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Fraiman all
Name of Insurance Company

Insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Fraiman may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative **Date**

Office Policy

Cancellations / Appointment Changes:

At 24 hours notice is required for cancellation and / or rescheduling appointments. Please call during office hours because the after-hours answering service does not accept appointment changes. Failure to notify the office prior to 24 hours will result in a $75.00 fee per hour of scheduled time.

Financial:

Payment is expected on the day that dental services are rendered.

Financial arrangements must be made in advance as a condition of your treatment by this office.

If your account requires collection proceedings, you will be responsible for the collection fees, legal fees, in addition to the balance and interest. A service charge of 1.5% per month (18% per annum) will be charged on unpaid balances exceeding 60 days, unless previously written financial arrangements are satisfied.

Insurance:

Reimbursement from your insurance is not guaranteed, the patient is ultimately responsible for all charges.

The estimated co-insurance payment is subject to change. Coverage approximate is based on the information provided by your insurance during verification and may not disclose specific restrictions.

The patient is responsible for all denied claims or procedures. If the claim is not paid by the insurance in a timely manner (45 days), the unpaid balance will be immediately due by the patient. The patient can then contact the insurance company for a reimbursement.

I have read and accept the terms of the above specified policies

Signature: _____ Date _____

Fraiman Prosthodontics

HEALTH HISTORY FORM

Name:_____ Date:_____

Date of Birth: _____ Sex: M / F Height:_____Weight: _____

Who can we thank for referring you to our office? _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health?.....Yes No
2. Has there been any change in your health in the past year? .....Yes No
3. My last physical exam was on _____/_____/_____
4. Are you now under the care of a physician?.....Yes No
   If so, for what condition? _____
5. The name and address of my physician is:_____
   _____
6. Have you had any serious illness, operation or hospitalization within the past 5 years?.....Yes No
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? .....Yes No
8. Are you taking any medicine(s) including non-prescription, homeopathic or "natural" remedies including diet pills .....Yes No
   If so, please list_____
9. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves, artificial valves or heart murmur .....Yes No
   b. Rheumatic Heart Disease .....Yes No
   c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition.....Yes No
      1. Chest pain upon exertion? .....Yes No
      2. Shortness of breath after mild exercise?.....Yes No
      3. Do your ankles swell? .....Yes No
   d. Allergies .....Yes No
   e. Sinus trouble.....Yes No
   f. Asthma or hay fever .....Yes No
   g. Fainting spells or seizures .....Yes No
   h. Diabetes.....Yes No
   i. Hepatitis, jaundice or liver disease .....Yes No
   j. Frequent or recurring mouth sores.....Yes No
   k. Thyroid problems .....Yes No
   l. Respiratory problems, emphysema, bronchitis, etc. .....Yes No
   m. Arthritis or painful, swollen joints including jaw joint (TMJ).....Yes No
   n. Stomach ulcer or hyperacidity.....Yes No
   o. Kidney trouble.....Yes No
   p. Tuberculosis .....Yes No
   q. Persistent cough or cough that produces blood .....Yes No
   r. Persistent swollen neck glands .....Yes No
   s. Low blood pressure .....Yes No
   t. Epilepsy or neurological disorder.....Yes No
   u. Are you taking vitamins or homeopathic remedies .....Yes No
   v. Cancer.....Yes No
   w. Any disease, drug or transplant operation that has depressed your immune system .....Yes No
10. Have you had abnormal bleeding?.....Yes No
    a. Have you ever required a blood transfusion? .....Yes No
11. Do you have any blood disorder such as anemia? .....Yes No
12. Have you ever had treatment for a tumor or growth?.....Yes No
13. Are you allergic to or have you had a reaction to:
    a. Local anesthetics .....Yes No
    b. Penicillin or antibiotics.....Yes No
    c. Sulfa drugs.....Yes No
    d. Barbiturates or sleeping pills .....Yes No
    e. Aspirin.....Yes No
    f. Iodine.....Yes No
    g. Codeine or other narcotics.....Yes No
    h. Latex or rubber products .....Yes No

i. Other ..... Yes No

14. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
    If so, explain: _____
    _____
15. Do you have any other condition or disease you think the doctor should know about? ..... Yes No
    If so, explain: _____
16. Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel or Boniva), for osteoporosis, chemotherapy (Aredia or Zometa) for multiple myeloma, or other cancers? ..... Yes No
17. Are you wearing removable dental appliances? ..... Yes No
18. Do you wish to talk with the doctor privately about anything? ..... Yes No

Women

19. Are you pregnant or trying to become pregnant ..... Yes No
20. Are you nursing? ..... Yes No
21. Are you taking birth control pills? ..... Yes No

DENTAL:

Chief Dental Complaint: _____
_____
_____

22. Are you currently in pain? ..... Yes No
23. Have you ever been under the care of an orthodontist, periodontist, or prosthodontist? ..... Yes No
24. Are you familiar with dental implants? ..... Yes No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Patient's Signature: _____

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: _____
_____
_____
_____

Significant findings from questionnaire or oral interview: _____
_____
_____
_____

Dental management considerations: _____
_____
_____
_____

Date: _____ Doctor's Signature: _____

Medical History Update:

Date	Comments	Signature

Fraiman Prosthodontics
Authorization to Release Health Care Information

Patient's name: _____ Date of birth: _____

SSN: _____ Previous name: _____

Doctor's Name _____

Practice Name: _____

I request and authorize the above listed doctor and practice to release health care information of the patient named above to:
Name: _____

Address: _____

City, State: _____ Zip code: _____

This request and authorization applies to health care information relating to the following treatment, condition, or dates of treatment:
_____

_____

Or _____ All health care information

Or _____ Other: _____
_____

THIS AUTHORIZATION EXPIRES ON _____ or _____DAYS AFTER THE DATE IT IS SIGNED; or WHEN THE FOLLOWING EVENT OCCURS _____
_____

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can:

- Sign and date a form available from the doctor or practice called "Revocation of Authorization for Use and Disclosure of Health Care Information" or

- Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

_____
Signature of patient or patient's authorized representative Date signed

_____
Relationship or status if signed by parent, legal guardian, personal representative, etc.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
(HIPAA ACT)

PRIVACY POLICY ACKNOWLEDGEMENT

Fraiman Prosthodontics (Perry H. Fraiman, DDS)

PATIENT NAME:_____ DATE:_____
PATIENT'S DATE OF BIRTH: _____ SS# _____
I verify that the information given on health history form is true and correct.

- I understand that the office and staff of Fraiman Prosthodontics will make every reasonable effort to protect my personal health information including my social security number, date of birth, address, and phone numbers.
- I understand that there may be times when the doctor and staff will need to speak with me regarding an appointment time, a test result or financial arrangements. If I am not at the number given, they have my permission to leave a brief message at my home or work number provided.
- I give my permission to Fraiman Prosthodontics and staff to correspond with my general dentist, general physician, or specialist that I am under care with.
- I understand that my test result or health information will only be given to me or my legal guardian and cannot be given to my spouse or other family members.
- Upon my request, I will be given a full and complete copy of HIPAA privacy policy.
- If there are specific restrictions on use of my personal health information, I will notify Fraiman Prosthodontics or Dr. Fraiman in writing of these restrictions.

_____ _____
Signature of Patient or Guardian Date