CORNERSTONE DENTAL

Cornerstone Dental, LLP
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Rochester, NY 14616
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Love Your Smile!

Welcome to Cornerstone Dental

Thank you for choosing us to be part of your healthcare team. We are very happy to have you join our practice and we appreciate the confidence you have placed in us to care for your oral health care needs.

Our primary goal is the preservation of your oral health. Optimal oral health is a lifetime commitment and we are devoted to helping you ***"Love Your Smile!"***. Our desire is to foster relationships that are based on mutual trust and understanding, open communication, and excellent customer service.

Our Pledge:

> We at Cornerstone Dental, through continued medical and dental education, are devoted to your oral health. We will do everything possible to provide you with the best treatment, the most up-to-date practice philosophies, and the most current oral health information in a fun and pleasant environment...so that we may help you ***"Love Your Smile!"***

We are a full service dental practice offering a comprehensive range of dental services to meet your individual needs, schedule, and budget. No individual is the same and your treatment plan will be carefully designed and tailored specifically to you. We strive to assist you in achieving your oral health care goals by using the most current information and up-to-date practice philosophies. We focus on creating a comfortable family atmosphere while providing gentle and efficient care.

We understand that financial concerns may exist for many patients. We believe that financial hardship should never stand in the way of health care. Open communication can benefit both parties, so please discuss your circumstances with any of our Patient Care Coordinators so that payment arrangements can be made as early as possible.

Again, welcome to our practice and thank you for choosing Cornerstone Dental for all your oral health care needs! Please visit our website at www.cornerstonedentalny.com to learn more about our practice, the doctors, and our office hours.

Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____

SS#/SIN _____

Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License# _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group# _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group# _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actoncl or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Do you have or have you had any of the following?		

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insuranee benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X _____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments _____

_____ Signature _____ Date _____

CORNERSTONE DENTAL 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 or PHI, 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 September 1, 2013, 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. The privacy of your health information is important to us.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose your PHI 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/disclose your PHI for your treatment. For example, we may disclose your health information to specialists providing treatment to you as well as dental labs, etc.

Payment. We may use and disclose your PHI 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 PHI 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 PHI 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 PHI to assist in disaster relief efforts.

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

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.

Public Health Activities. We may disclose your PHI 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 PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, PHI required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody, the PHI of an inmate or patient.

Secretary of HHS. We will disclose your PHI 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.

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 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 PHI in accordance with applicable laws and regulations. To request an accounting or disclosures of your health information, you must submit your request in writing to the Privacy Official listed at the end of this Notice. 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 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 PHI 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 have you requested, we may contact you using the information we have.

Amendment. You have the right to request that we amend your PHI. 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 (email).

QUESTIONS AND COMPLAINTS

If you would like 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 PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI 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.

Our Privacy Official: Jennifer Seefeldt ▪ Email: jseefeldt@cornerstonedentalny.com ▪ 3770 Mt. Read Blvd. ▪ Rochester, New York 14616 ▪ (585) 865-7030 ▪ Fax (585) 865-1425

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Cornerstone Dental's Notice of Privacy Practices provides information about how protected health information (PHI) about me (the patient) may be used or disclosed. I have been offered an opportunity to review the Notice, object to the use or disclosure of my PHI, and/or request restrictions as to how my PHI may be used or disclosed for treatment, payment, or healthcare operations before signing this consent. Cornerstone Dental is not required to agree to any restrictions, but if they agree, will be bound by the agreement. I understand that the terms of the Notice may change and I may obtain a revised copy by contacting the office at (585) 865-7030 or by visiting the office's website at www.cornerstonedentalny.com. I also understand that by refusing to sign this consent or revoking this consent, Cornerstone Dental may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I authorize Cornerstone Dental to discuss and/or release my PHI to the following individuals:

_____

_____

I wish to have the following restriction with regard to the use or disclosure of my PHI:

_____

_____

FOR OFFICE USE ONLY

Attempts were made to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify): _____

EE Initials: _____

By signing below, I acknowledge that I have received a copy of and understand Cornerstone Dental's Notice of Privacy Practices.

➢ _____

Signature Printed Name Date

CONSENT FOR DENTAL PROCEDURES, TAKING OF X-RAYS, ADMINISTRATION OF ANESTHETICS, AND THE RENDERING OF SERVICES

Patient (print): _____ DOB: _____Date: _____

I hereby request and authorize Cornerstone Dental, any associate dentists, hygienists, assistants, and/or such other qualified personnel as may be selected, to perform Routine Dental Care, a Comprehensive Oral Evaluation and any diagnostics including x-rays and/or any other therapeutic procedure that is in his/her judgment, advisable for the above- named patient's well-being.

The nature and purpose of the procedures and anesthetic, the risks involved, and the possibility of complications have been explained to me. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained. The advantages and inherent risks of anesthesia have been explained to me and I authorize the administration of such anesthesia as may be considered necessary or desirable.

I authorize that any specimens, tissue or parts removed from me or the above-named patient be disposed of in accordance with established practice.

In some instances, a referral to a specialist may be indicated. If I or the above-named patient requires the services of a specialist, I agree to accept the referral and will be responsible for any expense that may be incurred.

I hereby acknowledge and agree that if my dental insurance does not cover the treatment authorized above, I will be personally responsible for paying the financial charges for those services.

I certify that I have read this consent, or that it has been read to me, and that I understand the above. I have had an opportunity to ask questions and had these questions addressed to my satisfaction.

➢ _____

Signature of Patient (or Person Authorized to Sign for Patient) Relationship to Patient