# Patient Health Record

In order to help us render the proper dental services to you, would please be kind enough to answer the following questions. Please note the space for remarks for any answers that require clarification or any other information you think we should have. Thank you for your cooperation.

**DATE**_____

***Patient's Name:*** _____Child or Adult_____
(First) (Middle) (Last)
**Address** _____**Home Phone**_____

_____**Cell Phone**:_____
City, State Zip
**Patient Social Security # _____** **Email**_____

**Pt's Birth Date: _____** **Sex** : M / F Height_____Weight_____

Business phone_____ Occupation_____ **Adult patient or guardian's SS#** _____
Martial Statue Single_____ Married_____ Widowed_____ Divorced_____
Spouse's Name ____ _____

**Referred by**_____ convenient time for appointments_____

***MEDICAL HEALTH***
General Health (Please check) EXCELLENT ____ GOOD ____ FAIR ____ POOR _____
Name, Address of Physician _____Phone # _____
_____
LAST Complete physical?_____
Is the patient presently under the care of a physician? Yes__ _No____
Is the patient taking any medication now? Yes __ No __ If Yes, for what purpose?_____
Please list medications?:_____

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Has the Patient ever been treated for or diagnosed with:

| | | | | | |
|---|---|---|---|---|---|
| AIDS. . . . . | Yes__ | No__ | Allergies . . . . . | Yes__ | No__ |
| Abnormal Blood Pressure | Yes__ | No__ | Osteoporosis medications, such as Fosemax, Boniva, | | |
| Heart Disease . . . .. . . . . . | ..Yes __ | No__ | Reclast or any Bisphosphonates . . . . . .Yes __ | | No__ |
| Anemia . . . . . | Yes __ | No __ | Orthopedic implants, incl Joints Knee, Hip | Yes__ | No__- |
| Asthma or hay fever . . . . . | Yes __ | No __ | Arthritis. . . . . | Yes __ | No__ |
| Liver Disease (incl Jaundice) . . | Yes __ | No __ | Tuberculosis or lung disease . . . . . | Yes__ | No__ |
| Hepatitis . . . . . ... . | Yes __ | No __ | Respiratory problems . . . . . | Yes __ | No__ |
| Diabetes . . . . . | Yes __ | No __ | . . . . . | | |
| Sinus Trouble . . . . . | Yes __ | No__ | Cancer . . . . . | Yes__ | No__ |
| Epilespy /Seizure | Yes __ | No__ | Stroke/TIA . . . . . | Yes __ | No__ |
| HIV/ARC. . . . . | Yes __ | No__ | Do you have a pacemaker? . . . . . | Yes __ | No__ |
| Kidney Disease . . . . . | Yes __ | No __ | | | |
| Pregnant. . . . . | Yes-__ | No__ | How long?__ _Are you nursing an infant? | Yes__ | No___ |

Allergy to Codeine_____ Penicillin_____ Local injections_____ Latex_____ Other Med____

Has the patient ever been hospitalized? (Other than Childbirth): Explain_____
Has the patient ever been treated (other than Diagnostic) with x-ray? . . . . . . . . . . . . . . . . . . . . . . . Yes __ No__
Is the patient subject to prolonged bleeding? . . . . . Yes __ No__
Is the patient subject to fainting spells? . . . . . Yes __ No __
Does the patient have excessive urination and/or thirst? . . . . . Yes __ No __
Does patient smoke? Yes ___ No ___ If yes, how much per day? _____ For how long? _____

## ***Dental History***

Reason for visit:_____

When was the patient's last dental visit? _____

Has the Patient ever had any serious problem associated with previous dental treatment? Yes __ No__
If so, please explain?_____
_____

How often does he/she brush their teeth? _____

Has a dentist ever told the patient that they have gingivitis, gum disease or Pyhorrea? . . Yes __ No__

Does the patient avoid brushing or flossing mouth because of pain? . . . . . Yes __ No__
If yes, where? _____

Does the patient have pain or sensitivity with their teeth with (Circle all that apply) hot. . .cold .. .sweet. . .sour . . .

Does the patient have pronounced fear or higher anxiety with dental visits? . . . .. . . . . . Yes __ No __
If so, has this prevented he/she from pursuing proper treatment in the past? . .. . . . . . Yes __ No __

Does the patient clench or grind while sleeping or during the day? . . . . . .. .. . Yes __ No __

Does the patient's jaws ever feel tired, click, pop, or have difficulty opening? . . . . . Yes__ No__

Does the patient gag easily? . . . . . Yes__ No__

Are you interested in discussing any Cosmetic procedures such as Tooth Whitening, Bonding, Etc? Yes__ No__

Please add anything you feel is important_____
_____
_____
_____
_____

PLEASE SIGN FORM:

X_____ /_____ /____

***Patient or Guardian's Signature if Patient is Child) (Relationship to Patient) Date***

# Sal R. Varano, D.D.S

{NAME OF PRACTICE}

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**SECTION A: PATIENT GIVING CONSENT**

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient #: _____ Social Security #: _____

**SECTION B: TO THE PATIENT— PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of you protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Telephone: **516 481 2380** Fax: **516 505 5347**

Email: **varanodental@optonline.net**

Address: **25 Nassau Boulevard, Garden City So., NY 11530**

**Right to Revoke:** Your will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Information listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent.

**SIGNATURE**

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**
**Include completed Consent in the patient's chart.**

## Sal R. Varano, D.D.S

{NAME OF PRACTICE}

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of the office's Notice of Privacy Practices.

_____
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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____


**Financial Policy - *Sal R. Varano, DDS, PC***

We are committed to providing you with the best possible care and your clear understanding of our financial policy is important to our professional relationship. Please feel free to discuss any questions you have about our fees and financial policy, your insurance coverage and ***your*** financial responsibility with our doctor or clerical staff.

Insurance rules are complex and policy and procedure specific. We will attempt to determine which policy applies and which coverage is primary, and in order to maximize your benefit, it is ***critical*** that you provide us with **all** of your insurance information. Failure to provide complete information may reduce or invalidate your coverage.

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*****Pt with insurance*** -- **You are responsible for the payment of all co-payments, co-insurance, deductibles and *non-covered expense.***

**As a service and courtesy to you, our office will do all the insurance paperwork and submit insurance claims to the carrier for your convenience, however you as the patient and /or the guarantor of the account are ultimately responsible for the balance on the account, regardless of what the insurance company does or does not pay. Claims will be submitted for payment at the time the services are rendered. *Any co-payments are expected at the time of treatment.***

If the insurance coverage is for a dependent who is a full time student, you must provide your insurance with the appropriate documentation such as the Bursar's bill. If you fail to do so, you will be responsible for the fees and you may lose your ability to obtain reimbursement from the insurance company. This is beyond our control.

If you have not paid the doctor, and the insurance carrier inadvertently pays you, you must send this payment immediately to our office

Please understand that you responsible for a *yearly deductible* and on average 20-60% co-payments which are dictated by the Group Insurance you subscribe. With the information you or your carrier has provided to us, we will try to estimate as closely as possible the co-payments (if any) for your treatment. Please be aware these are only estimates and not final numbers. Also understand that you are responsible for non-covered services and certain elective services, (some procedures may not be covered such as nitrous oxide, bleaching, sealants etc.) Unpaid balances will be subject to late charges.

***Patient without insurance ---*Treatment fees are due are time of service.***
***Unpaid balances are subject to late charges.***

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorized the office of Dr. S. R. Varano, DDS, PC to disclose portions of the patient record as requested by the insurance carrier.

I have read the above financial policy and agree to abide by the information.

**I acknowledge that I have received the Notice of Privacy policies of Dr. Sal Varano, DDS, PC and have been given an opportunity to read the Notice prior to signing the acknowledgement. I understand the policies and consent to the release of "protected health information" for treatment, payment and healthcare operations, as defined and allowed by Federal law (HIPPA). I understand I may revoke this consent at any time: however, the revocation must be in writing and is not retroactive.**

**I have received a copy for my records _____ Initial**

_____ _____

**Signature of Patient or Guardian** **Date**

# Dental Claim Form



## HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

## INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

## OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

| 6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#) |
|---|---|---|
| 9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other | |

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

## POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

| 13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#) |
|---|---|---|
| 16. Plan/Group Number | 17. Employer Name | |

## PATIENT INFORMATION

| 18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use |
|---|---|

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

| 21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist) |
|---|---|---|

## RECORD OF SERVICES PROVIDED

| | 24. Procedure Date (MM/DD/CCYY) | 25. Area of Oral Cavity | 26. Tooth System | 27. Tooth Number(s) or Letter(s) | 28. Tooth Surface | 29. Procedure Code | 29a. Diag. Pointer | 29b. Qty. | 30. Description | 31. Fee |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | |
| 2 | | | | | | | | | | |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |
| 7 | | | | | | | | | | |
| 8 | | | | | | | | | | |
| 9 | | | | | | | | | | |
| 10 | | | | | | | | | | |

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ ( ICD-9 = B; ICD-10 = AB )

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

## AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____

Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____

Subscriber Signature Date

## BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

| 49. NPI | 50. License Number | 51. SSN or TIN |
|---|---|---|
| 52. Phone Number ( ) - | 52a. Additional Provider ID | |

## ANCILLARY CLAIM/TREATMENT INFORMATION

| 38. Place of Treatment ☐ (e.g. 11-office; 22-O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐ |
|---|---|
| 40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY) |
| 42. Months of Treatment Remaining | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) |
| | 44. Date of Prior Placement (MM/DD/CCYY) |

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

| 46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State |
|---|---|

## TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X

Signed (Treating Dentist) Date

| 54. NPI | 55. License Number |
|---|---|
| 56. Address, City, State, Zip Code | 56a. Provider Specialty Code |
| 57. Phone Number ( ) - | 58. Additional Provider ID |