ROBERT T. GOLD, D.D.S.

Restorative, Cosmetic and Implant Dentistry

2018 Albany Post Road | Croton-on-Hudson, NY 10520 | 914-271-4726

PATIENT REGISTRATION AND MEDICAL HISTORY (Please Print)

Date _____ Home Phone ( ) _____

Patient Last Name _____ First Name _____ M.I. ____ Preferred Name _____

Street Address _____ City _____ State _____ Zip _____

E-mail _____ Cell Phone ( ) _____

Sex ☐ M ☐ F Age ____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

If patient is a minor, what is his/her weight? _____ ☐ Separated ☐ Divorced ☐ Partnered for ___ years

Employer / School _____

Employer / School Address _____ Employer / School Phone ( ) _____

Spouse / Parent Name _____ Spouse / Parent Birthdate _____

Spouse / Parent Employed by _____

Business Address _____ Business Phone ( ) _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse / Parent's SS # _____

Driver's License # / State _____

PRIMARY INSURANCE

Name of Dental Insurance Company _____ Group # _____

SECONDARY INSURANCE (if applicable)

Name of Dental Insurance Company _____ Group # _____

In case of emergency, who should be notified? _____ Phone ( ) _____

Whom may we thank for referring you? _____

Is patient a full-time college student over 18 years old? ☐ Yes ☐ No

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following (check boxes that apply):

☐ Artificial Heart Valves	☐ Headaches	☐ Radiation Treatment
☐ Artificial Joints/Screws	☐ Heart Problems	☐ Recent Weight Loss
☐ Back Problems	☐ Hemophilia	☐ Respiratory Disease
☐ Bleeding Abnormally	☐ Hepatitis, Jaundice or Liver Disease	☐ Rheumatic Fever
☐ Blood Disease	☐ High Blood Pressure	☐ Sinus Problems
☐ Cancer	☐ HIV / AIDS	☐ Sleep Apnea
☐ Chemical Dependency	☐ Kidney Problems	☐ Special Diet
☐ Circulatory Problems	☐ Low Blood Pressure	☐ Stroke
☐ Diabetes	☐ Nervous Problems	☐ Swollen Neck Glands
☐ Epilepsy	☐ Psychiatric Care	☐ Ulcer

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? ☐ Yes ☐ No

If so, what? _____

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

Are you taking any medications at this time? ☐ Yes ☐ No If so, what? _____

Have you ever taken Bisphosphonate medications (e.g. Fosamax)? ☐ Yes ☐ No

Are you currently under the care of a physician? ☐ Yes ☐ No If so, for what? _____

(WOMEN) Do you suspect that you are pregnant? ☐ Yes ☐ No If so, Due Date _____

Are you nursing? ☐ Yes ☐ No Taking Birth Control Pills? ☐ Yes ☐ No

Anything else we should know about your medical history _____

Are you happy with your smile? ☐ Yes ☐ No If no, why not? _____

ROBERT T. GOLD, D.D.S.

CERTIFICATION

To the best of my knowledge, the information provided on this form is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health.

Signature _____ Date _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I and/or my dependents are covered by insurance with
and assign directly to Dr. Robert Gold all 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 my insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's 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 _____ Date _____

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made.
I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges. We reserve the right to charge 1.5% interest per month on all delinquent accounts. Any collection fees will be added to delinquent accounts.

Appointments cancelled with less than 24 hours notice will be charged a sliding fee ($75 minimum) based on the length of the appointment.

Signature _____ Date _____
(Patient, Parent or Guardian)

_____ _____
Please print name of Patient Parent or Guardian Relationship to Patient

ROBERT T. GOLD, D.D.S.

NOTICE OF PRIVACY PRACTICES FOR THE OFFICE OF ROBERT T. GOLD D.D.S.

This notice describes how health information can be used and disclosed and how you can get access to this information.

Our legal duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice of our privacy practices, our legal duties and your rights regarding your health information. We must follow these privacy practices that are described in this notice. We reserve the right to change our privacy practices. This document takes effect on April 1, 2008.

Uses and disclosure of health information

Treatment – We may use or disclose your health information to a physician or other healthcare provider providing treatment for you
Payment – We may use and disclose your health information to obtain payment for services we provide to you
Healthcare operations – We may use and disclose your health information in connection with quality assessment and improvement activities, accreditation, certification, and licensing activities
Your authorization – Unless you give us written authorization we may not use or disclose your health information in any manner other than that which is described in this notice.
To your family and friends – We must disclose your health information to you as described below in the patient's rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons involved in care – We may use or disclose health information to notify, or assist in the notification of (including locating) a family member, your personal representative or another person responsible for your care. We may disclose to them your location, general condition, or death. If you are present, then prior to use or disclosure of your health information we will provide you with an opportunity to object to such use or disclosures. In the event of your incapacity or emergency circumstances we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person(s) involved in your healthcare. We will also use our professional judgment along with experience and common practice to make reasonable inferences with regard to your best interests in allowing a person to pick up filled prescriptions, medical supplies, x rays, or other similar forms of health information.
Marketing related health services – We will not disclose or use your health information without your written authorization.
Required by law – We may use or disclose your health information when required to do so by law
Abuse or neglect – We may disclose to appropriate authorities your health information if we reasonably believe you to be a possible victim of abuse, neglect, domestic violence, or the victim of other crimes. We may disclose your health information to avert a serious threat to your health and safety or the safety and health of others
National security – We may disclose to military authorities the health information of armed forces personnel under certain circumstances as required by law. We may disclose to authorized federal officials when required for lawful

intelligence, counter intelligence, or other national security activities. We may disclose to correctional institutions or law enforcement officials who have lawful custody of protected health information under certain circumstances

Appointment reminders – We may use or disclose your health information to provide you with appointment reminders (such as postcards, letters, voicemail or text messages)

Patient rights

Access – You have the right to look at or get copies of your health information, with limited exceptions. You may request the form in a format other than photocopies. We will use the information you request unless we cannot practicably do so. You must make a request in writing for your health information. You may obtain a form to request access by using the contact information at the end of this notice. We will charge you reasonable fee based upon copier usage and staff time. You may also request access by sending a letter to the contact information below. If you request copies we will charge $0.25 per page plus postage of you want the copies mailed to you. If you request another format we will calculate a fee based upon cost for providing your information in that format. If you prefer we will provide a summary or explanation of your health information for a fee.

Disclosure accounting – You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment or healthcare operations for the last six years. If you request this more than once in 12 month period we may assess you a fee based upon our costs.

Restriction – You have the right to place additional restrictions on our use or disclosure of health information. We are not required to agree to these additional restrictions, but if we do so we will abide by them except in case of emergency.

Alternative communication – You have the right to request that we communicate with you regarding your health information by an alternate means or to alternate locations (you must make a request in writing). Your request must specify the alternate means or location and explain satisfactorily how payments will be handled under the alternate means or location you request.

Amendment – You have the right to request that we amend your health information (this must be done in writing and explain why it should be amended). We may deny your request under certain circumstances.

Electronic notice – If you receive this notice electronically you may also request a written form.

Questions and complaints

If you want more information about our privacy practices or have questions or concerns please contact us using the information below

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or response to a request we you made to amend or restrict the use and disclosure of your health information or have us communicate with you by alternative means or location you may complain to us at the address listed at the end of this notice. You may also complain to the US Department of Health and Human Services located at 200 Independence Avenue, S.W. Washington, D.C. 20201 or you may call them at (202) 619 – 0257. We support your right to privacy and will not retaliate in any way if you should choose to file a complaint with the US Department of Health and Human Services.

Contact officer
Dr. Robert Gold
2018 Albany Post Road
Croton-on-Hudson, NY 10520
Phone - (914) 271 - 4726
Fax – (914) 271 – 1364

ROBERT T. GOLD, D.D.S.

Acknowledgement of Receipt of Privacy Practices

You may refuse to sign this acknowledgement

I _____ have received a copy of Dr. Robert Gold's office privacy practices.

_____ _____

Signed Date

For office use

We attempted to obtain written acknowledgement of privacy practices but could not because:

- Individual refused to sign
- Communication barriers prohibited acknowledgement
- An emergency procedure prevented us from obtaining acknowledgement