Millennium Periodontics

25 Walton Street • Saratoga Springs, NY 12866
P: 518-314-1885 • F: 518-430-2007
millenniumperio12866@gmail.com
Neda Azadivatan-Le, DDS

Patient information

Patient's First Name	Middle Name	Last Name (as it appears on insurance card or ID)
Sex Marital Status	Date of Birth (Age)	Social Security Number

Patients Address	City	State	Zip

Home Phone	Mobile Phone	Email Address

Referred by

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Reason for Visit

What brings you to the office today?

Current Medications

Are you currently taking any blood thinners?
☐ YES ☐ NO
What medications are you currently taking?

Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency

Lifestyle Factors

Have you ever smoked?
☐ YES ☐ NO # of years ________ # of packs per day __________

Do you smoke now?
☐ YES ☐ NO # of packs per day__________

Do you use recreational drugs?
☐ YES ☐ NO Types ______________ # times per week _______

How much alcohol do you drink per week?
# of drinks per week?__________

How much caffeine do you drink per day?
# of cups per day?__________

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates *(Sleeping Pills)* ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction
Name	Reaction

Hospitalizations & Surgeries

Reason	Date
Reason	Date
Reason	Date
Reason	Date

Women Only

Are you pregnant? ☐ YES ☐ NO
Are you pregnant? ☐ YES ☐ NO
What is your method of birth control?

Your Pharmacy

Pharmacy Name

Pharmacy Phone

Pharmacy Address

City State ZIP

Dental History

When was your last dental exam?
Date ____________________

When were your last dental x-rays taken?
Date ____________________

How often do you floss?
# of times per day________

How often do you brush?
# of times per day________

Do you grind your teeth?
☐ YES ☐ NO

Have you ever had Orthodontic (Braces) treatment?
☐ YES ☐ NO

Have you ever had periodontal (gum) Treatments?
☐ YES ☐ NO

Do you have any of the following?

☐ Bad Breath
☐ Bleeding Gums
☐ Blisters on Mouth
☐ Broken Fillings
☐ Clicking Jaw
☐ Dentures
☐ Difficulty Opening or Closing Mouth
☐ Dry Mouth
☐ Difficulty Chewing
☐ Ear Pain
☐ Jaw Pain
☐ Loose Teeth
☐ Mouth Pain
☐ Partials
☐ Sensitivity to Cold
☐ Sensitivity to Heat
☐ Sensitivity to Sweets
☐ Sensitivity to Pressure
☐ Swollen Gums
☐ Mouth Sores

Past Medical History

Have you ever had any of the following?

☐ Alcoholism
☐ Allergies
☐ Anemia
☐ Anxiety Disorder
☐ Arthritis
☐ Asthma
☐ AIDS / HIV
☐ Bleeding Disorder
☐ Blood Disease
☐ Blood Transfusion
☐ Bowel Disorder
☐ Cancer
☐ Diabetes
☐ Depression
☐ Eating Disorder
☐ Epilepsy
☐ Hay Fever
☐ Heart Disease
☐ Heart Problems
☐ Hepatitis - A, B, or C
☐ High Blood Pressure
☐ High Cholesterol
☐ Joint Disorder
☐ Kidney Disorder
☐ Liver Disorder
☐ Lung Disease
☐ Lupus
☐ Measles
☐ Migraines
☐ Osteoporosis
☐ Pacemaker
☐ Rheumatic Fever
☐ Sinus Problems
☐ Skin Disorder
☐ Stroke
☐ Stomach Ulcer
☐ Substance Abuse
☐ Thyroid Disorder
☐ Tuberculosis
☐ Venereal Disease

Billing and Insurance

Primary Dental Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	
Insured's Name *(as It appears on insurance card or ID)*		Relation to Patient	Insured's Phone Number
Insured's Address		City	State Zip
Insured's Social Security Number	Insured's Birthdate		

Secondary Dental Insurance

Insurance Company			
Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number
Insured's Name (as it appears on Insurance card or ID)		Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name *(if other than patient)*	Phone	Relation to Patient	
Address	City	State	Zip

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
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

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 our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization :ln addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information , and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

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 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 with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

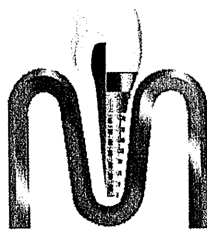
PATIENT ACKNOWLEDGMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

____ ____________________

Print Patient's Name Date

I ____, acknowledge that I (Signature of Patient or Parent or Legal Guardian) have either received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I ____, consent to the use and disclosure of *(Signature of Patient or Parent or Legal Guardian)* my personal health information by your office for Treatment, Billing / Payment and Health care Operations as outlined in the **NOTICE OF PRIVACY PRACTICES.**



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APPOINTMENT CANCELLATION POLICY

We strive to render excellent dental care to you and the rest of our patients. We know your time is valuable, so in an attempt to be consistent with this, we schedule exclusive appointment times that are reserved only for you. We do not double book appointments which means that time has been set aside for you and cannot be used to treat another patient.

We require that patients give our office **48 hours notice** in the event that they need to reschedule an appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment and a fee of $300.00 will be charged to you. This fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

We strive to always be on time for our patients and therefore if you are late to your appointment we may need to reschedule you so we can stay on time for our other patients.

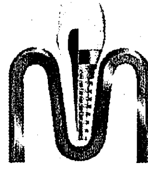
If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I ______________________________ *(print name),* agree to the Millennium Periodontics Appointment Cancellation Policy.

____ ____________________

Signature Date



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UNDERSTANDING YOUR FINANCIAL CHOICES

When you make any decision regarding dental treatment, it is important that you understand the financial decision you are making at the same time. We are committed to fully informing you of your financial responsibility prior to treatment.

You are responsible for the cost of treatment provided in our office.

- To support your financial responsibility, we will always tell you in advance of providing any dental service what your expected cost will be.

If you have a dental insurance plan, we will work with you to understand your anticipated benefits as they apply to your treatment choices.

- We will help you determine how your plan reimbursement will affect your payment to our office for dental services, considering reimbursement method, levels of coverage, co-payments, deductibles, limits and services not covered.
- Please note that reimbursement from your insurance will be sent directly to you and payment is due at the time of service.

Your payment to our office is due on the day of service.

- For treatment that is completed in a single appointment, the full amount of your payment is due on the day of the appointment.
- For treatment that requires multiple appointments, we will inform you of the payment amount that is due at each appointment.
- Surgical procedures require a deposit at the time an appointment is made. The deposit is fully refundable in the event an appointment is rescheduled or cancelled with at least 48 hours notice.
- Outstanding balances on accounts over 60 days will be subject to a 5% late fee per month. Accounts with an outstanding balance beyond 90 days will be subject to collections. Any and all fees associated with collections will be the direct responsibility of the patient.

Payments can be made by cash, check debit card, Visa, MasterCard, American Express or Discover Card.

- When extensive dental treatment is planned, our office can facilitate financial arrangements with a third party dental finance company such as LendingClub and CareCredit.

I ______________________________ *(print name),* agree to the Millennium Periodontics financial Policy.

______________________________ ______________

Signature Date