Michel S. Adsit, D.D.S.
1000 Driving Park Ave.
Newark, NY 14513
(315) 331-6232

PATIENTS PERSONAL DATA:

Patient's Name: _____ If Child, Parent's name:_____
Address: _____ City_____ State _____ Zip _____
Patients Date of Birth: ___/____/_____ SS#:_____ Marital Status: ___Age:____Sex: ___
Home Phone ( )_____Cell ( )_____ Email Address: _____
Employer/Occupation: _____Work # ( ) _____
Spouse's Name: _____ Emergency Phone # ( )_____

DENTAL INSURANCE INFORMATION:

PRIMARY Ins. Carrier: _____
Name of Subscriber: _____
Name of Employer: _____
ID# & SS# of Subscriber/Gpr#_____Subscriber DOB ___/___/_____
SECONDARY Ins. Carrier: _____
Name of Subscriber: _____
Name of Employer: _____
ID# & SS# of Subscriber/Gpr#_____Subscriber DOB ___/___/_____

DENTAL HISTORY

How May I help you today? _____
Are you in pain or discomfort at this time? Y N Do you very feel nervous about having dental treatment? Y N
Do you habitually clench your teeth during the day or night? Y N Have you ever had a bad experience in the dental office? Y N
Do you now have bleeding gums? Y N Whom may we thank for a referral or how did you learn about our office? _____

MEDICAL HISTORY

Who is your primary physician? _____ Phone # ( ) _____
Other Physician/Specialist? _____ Phone # ( )_____
Do you have any current health problems? Y N Do you smoke, use chewing tobacco or snuff? Y N
Are you under a Physicians Care NOW? Y N If yes, please explain _____
Please list medications you are currently taking: _____
Are you Pregnant? Y N If yes, what month _____ Nursing? Y N Do you take birth control Pills? Y N

CHECK ANY OF THE FOLLOWING YOU HAVE HAD, OR PRESENTLY HAVE:

□ Heart Disease/Attack	□ Heart pacemaker	□ Kidney Disease	□ Hepatitis A (infectious)	□ Pain in Jaw joints
□ Angina Pectoralls	□ Heart Surgery	□ Thyroid Disease	□ Hepatitis B (serum)	□ Ulcers
□ High Blood Pressure	□ Stroke	□ Liver Disease	□ Blood Transfusion	□ Glaucoma
□ Other Heart Problems	□ Emphysema	□ Diabetes	□ Bruise Easily	□ Epilepsy or Seizures
□ Congenital Heart Lesions	□ Tuberculosis (TB)	□ Sickle Cell Disease	□ Radiation Treatment	□ Psychiatric Treatment
□ Mitral Valve Prolapse	□ Asthma	□ Hemophilia (bleeding problems)	□ Chemotherapy (cancer leukemia)	□ Eating Disorder
□ Rheumatic Fever	□ Hay Fever	□Anemia	□ Artificial Joints (hip, knees, other)	□ Nervousness
□ Heart Murmur	□ Allergies or Hives	□ A.I.D.S./A.R.C./H.I.V Pos	□ Cortisone Medications	□ Drug Addiction
□ Artificial Heart valve	□ Sinus Trouble	□ Venereal Disease	□ Arthritis	□ Alcoholism

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANYOF THE FOLLOWING? (CIRCLE THOSE THAT APPLY)
Aspirin, Nitrous Oxide, Local Anesthetics, Novocain or Xylocaine, Valium, Demerol, Codeine,
Percodan, Penicillin, Sulfa, Erythromycin, Tetracycline, Other Antibiotics, Metal, Other_____

Consent: The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patients' dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, and further authorize any consent that Doctor chose and employ such assistance as he/she deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a ½% finance charge (18% annually) will be added to any balance over 80 days. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs & reasonable attorney fees as may be required to collection of this note.

Patient_____ Date: _____/_____/_____ Witness: _____

Parent or Responsible Party: _____ Relationship to patient: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

_____