Mark Danziger DDS

2982 Delaware Ave

Kenmore, NY 14217

APPOINTMENT CANCELLATION POLICY

We reserve our office and staff solely for your care, and we ask that you honor the time and day that YOU have chosen for your appointment.

If circumstances arise that require you to change your appointment, we need a **MINIMUM OF 2 BUSINESS DAYS NOTICE.** Please note that we are open Monday through Thursday. For example if you need to cancel a Monday appointment, you would need to cancel that appointment on the Wednesday before. Then we have time to place another patient into your appointment slot. Please understand that the reminder calls, texts, and emails sent to confirm your appointment for you are done as a courtesy of this office.

Any patient that does not notify us of their inability to honor their scheduled appointment **PRIOR TO THE 48 HOUR TIME FRAME WILL BE CHARGED A MISSED APPOINTMENT FEE OF $50.**

We thank you for your anticipated. Also, as a reminder, it is important that you please respond to our text or email confirmations.

Please sign: _____

Healthy Smiles. Healthy Family. Happy Life.

New Patient Registration

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.

How did you learn of
Direct Mailing Friend/Relative Internet Search Insurance Plan Newspaper Ad Exterior Sign Facebook Twitter
Other_____ If you were referred, whom may we thank for referring you?_____

Patient Information

Name _____ Nickname _____ Sex M F
SSN _____ Birth date _____ Cell Phone _____
Address _____ Home Phone _____
City _____ State _____ Zip _____ Work Phone _____
Email _____ Facebook _____ Twitter _____
Check appropriate box: Minor Single Married Divorce Widowed Separated
If student, name of school _____ FT / PT City _____ State _____ Zip
Patient or parent/guardian's employer _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Emergency Contact _____ Phone _____

Responsible Party

Name of person responsible for account _____ Relationship to Patient _____
Address _____ Cell Phone _____
City _____ State _____ Zip _____ Home Phone _____
Email _____ DOB _____ Work Phone _____
Are you currently a patient of this office? Yes No Drivers License # / State _____
Employer _____ SSN _____

Insurance Information

Name of Insured _____ Relationship to Patient _____
DOB _____ SSN _____ Date Employed _____
Name of Employer _____ Address _____ Work Phone _____
City _____ State _____ Zip _____ Home Phone _____
Insurance _____ Group # _____ Policy/ID # _____
Insurance Address _____ City _____ State _____ Zip _____

Consent

I will answer all health questions on the Medical History From to the best of my knowledge_____ (Initials)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature _____ Date_____ Relationship to Patient_____

Healthy Smiles. Healthy Family. Happy Life.

FAMILY DENTISTRY

Patient Medical History Form

Dental History

Why have you come in to see us today? (e.g.: pain, checkup, etc.)? _____

What is your biggest concern about your gums, teeth and/or mouth? _____

Previous Dentist & Location _____ Date of Last Cleaning _____

Do your gums bleed when flossing?	Yes	No	Do you have frequent headaches?	Yes	No
Are your teeth sensitive to hot or cold?	Yes	No	Do you clench or grind your teeth?	Yes	No
Are your teeth sensitive to sweet or sour?	Yes	No	Do you have bad breath or mouth odors?	Yes	No
Do you have loose teeth?	Yes	No	Do you bite your lips or cheeks frequently?	Yes	No
Do you feel pain in any of your teeth?	Yes	No	Have you had difficult extractions in the past?	Yes	No
Do you have any sores or lumps in or near your mouth?	Yes	No	Have you had prolonged bleeding after extractions?	Yes	No
Have you had any head, neck, or jaw injuries?	Yes	No	Have you had any orthodontic treatment?	Yes	No
Do you have dental anxiety?	Yes	No	Do you wear dentures or partials?	Yes	No
Do you avoid brushing part of mouth due to pain?	Yes	No	If yes, date of placement: _____		
Have you ever experienced any of the following:			Have you ever received oral hygiene instructions		
Jaw clicking, popping or locking?	Yes	No	regarding the care of your teeth and/or gums?	Yes	No
Pain (jaw, joint, ear, side of face)?	Yes	No	Do you like your smile?	Yes	No
Difficulty opening or closing jaw?	Yes	No	Do you want your teeth straight?	Yes	No
Difficulty chewing	Yes	No	Do you want whiter teeth?	Yes	No

Medical History

Physician _____ Office Phone _____ Date of last exam _____

Are you under medical treatment now?	Yes	No	Do you use tobacco?	Yes	No
Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	Yes	No	Are you allergic to or have reactions to the following:		
Are you any medication(s), including non-prescription?	Yes	No	Local Anesthetics (e.g. Novocaine)	Yes	No
Have you ever taken Fen-Phen/Redux?	Yes	No	Sulfa Drugs	Yes	No
Have you ever taken any cancer medications?	Yes	No	Barbiturates	Yes	No
Do you use alcohol?	Yes	No	Penicillin or Antibiotics	Yes	No
Do you use controlled substances?	Yes	No	Sedatives	Yes	No
FOR WOMEN ONLY	Yes	No	Iodine	Yes	No
Are you pregnant or think you may be pregnant?	Yes	No	Aspirin	Yes	No
Are you nursing?	Yes	No	Any Metals (e.g. nickel, mercury, etc.)	Yes	No
Are you taking oral contraceptives?	Yes	No	Latex Rubber	Yes	No
	Yes	No	Other (please list below)	Yes	No
Do you have or ever had any of the following?	Yes	No			

High Blood Pressure	Yes	No	Diabetes	Yes	No	Chest Pains	Yes	No
Heart Attack	Yes	No	Heart Disease	Yes	No	Hay Fever Allergies	Yes	No
Rheumatic Fever	Yes	No	AIDS or HIV	Yes	No	Stroke	Yes	No
Swollen Ankles	Yes	No	Cardiac Pacemaker	Yes	No	Tuberculosis	Yes	No
Fainting/Seizures	Yes	No	Heart Murmur	Yes	No	Radiation Therapy	Yes	No

Medical History Cont.

Asthma	Yes	No	Angina	Yes	No	Glaucoma	Yes	No
Low Blood Pressure	Yes	No	Anemia	Yes	No	Recent Weight Loss	Yes	No
Epilepsy/Convulsions	Yes	No	Emphysema	Yes	No	Liver Disease	Yes	No
Leukemia	Yes	No	Cancer/Tumor	Yes	No	Heart Trouble	Yes	No
Kidney Disease	Yes	No	Arthritis	Yes	No	Respiratory Problems	Yes	No
Thyroid Problems	Yes	No	Joint Replacement/Implant	Yes	No	Mitral Valve Prolapse	Yes	No
Frequently Tired	Yes	No	Liver Disease/Jaundice	Yes	No	Hepatitis Type _____	Yes	No
Bleeding Disorder	Yes	No	Tuberculosis	Yes	No	Psychiatric Treatment	Yes	No
STD	Yes	No	Stomach Trouble/Ulcer	Yes	No	Other	Yes	No

If you answered YES to any questions above, please explain:

Medications

Please list any medications that you are currently taking:

AUTHORIZATION & 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.

X _____ Date _____

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

Patient Responsibility form

Patient Name:_____Date:_____

We are pleased to assist you with your dental insurance. If you have dental insurance, please be aware that insurance quotes are an ESTIMATE only. Coverage may be different if your deductible has not been met, annual maximum has been met, or if your coverage table is lower than average.

Co-pays:
I understand that I am responsible to pay all co-payment at the time of service, prior to leaving.

Deductible:
If my insurance determines that I have not met my deductible I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and/or provider.

I acknowledge that I assume full financial responsibility for services rendered to me, if my insurance carrier denies or does not cover my claim for these services. I understand the terms of this form and accept financial responsibility with or without the use of insurance coverage.

_____

Patient Signature/Guardian Date

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);

The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosure of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to theses requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this_____day of _____, 20___.

Print Patient Name:_____

Relationship to Patient:_____

Signature:_____

Dr. Mark Danziger

2982 Delaware Avenue

Kenmore, NY 14217

716-875-4243

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), all medical records and other individually identifiable protected health information (PHI) of which we have knowledge must be kept confidential. All PHI used by us or disclosed by us is covered by the Act regardless of whether this PHI is in electronic, oral or paper form. Several new rights are granted to patients under this Act, allowing control over how your PHI is used, how you can access it, and in some cases amend it.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI.

We may be assessed a penalty for any misuse or unauthorized disclosures of your personal health information as regulated by HIPPA.

This Notice of Privacy Practices is effective on January 1, 2015.

We are bound to abide by the terms of this notice and reserve the right to make revisions to this policy. Should revisions be made, you will be notified in writing, and a copy of the revised policy will be made available at your request.

Should any breach of unsecured PHI ever occur, we will notify the patient(s) involved within 10 business days of discovery of this breach.

You will be asked to sign a consent form authorizing us to use and disclose your personal health information only for the following purposes, as defined under the Act:

- Treatment means the provision, coordination, or management of health care and related services by one or more healthcare providers, including the coordination of management of health care by a healthcare provider with a third party; consultation between healthcare providers relating to a patient; or the referral of a patient for health care from one healthcare provider to another An example of this would be a dentist referral to an orthodontist.
- Payment means obtaining reimbursement for the provision of health care; determinations of eligibility of coverage; billing; claims management; collection activities; justification of charges; and disclosure to consumer reporting agencies; protected health information relating to the collection of reimbursements (only certain information may be disclosed.) An example of this would be submitting your bill for health care services to your insurance company.
- Health care operations are any activity related to covered functions in which we participate in the function of our offices, such as conducting quality assessment activities; protocol development; case management and care-coordination; auditing functions; business management and general administrative activities, including implementation of this regulation; customer service evaluations; resolution of grievances; fundraising; and marketing for which an authorization is not required. An example of this would be evaluation customer service given to patients.

Our Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological well being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care. We are always available to answer your questions or assist you in any way we can.

Financial Policy:
All of our fees or co pays will be due and payable at the time treatment is rendered. For our patients with dental insurance: We do our best to estimate your co-payment. The co-payment will be collected at the time of services. As a courtesy we will file your insurance claims. We can make no guarantee of any estimated coverage or payment. Because the insurance policy is an agreement between you and your insurance company, we ask that all patients be ultimately responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy.

Payment Options:

Cash or check	We are happy to accept full payment by cash or check. For major treatment plans a 5% immediate payment courtesy will be given when treatment is paid in full by cash or check on the day of treatment, although not in conjunction with any other discount plans. A 10% Senior Citizen discount will be available to our patients over age 62, although not in conjunction with any other discount plans.
Credit Cards	We are happy to accept MasterCard, Visa, Discover and AMEX.
Care Credit	By arrangement with CARE CREDIT, we are able to offer our patients an interest-free line of credit separate from your other credit cards. There are no application or annual fees, and no down payment necessary. Interest Free Guidelines: In the brochure, there are two interest free programs. Our office only participates in the three and six month interest free program. We will be happy to extend your payments, if needed, with Care Credit's low interest program.

Thank you,

The office of Mark A. Danziger, DDS