SMILE DESIGN
— CENTER —

WELCOME TO OUR PRACTICE!

On behalf of our staff, we welcome you to our office. We are pleased that you selected us to care for your dental needs and we look forward to your initial visit.

We want you to know that we are committed to provide you with the highest quality of oral health care in the most gentle, efficient, and enthusiastic manner possible. We pride ourselves on making dentistry a pleasant experience for you, while providing you with the best dental treatment.

Our emphasis is on early preventive care, but we also provide restorative care, including full mouth rehabilitation and emergency services. Our primary goal, whenever possible, is the retention of your healthy, natural teeth. With this in mind, let me tell you what you can expect on your first visit to our office.

During your first visit, a comprehensive examination will be completed. This exam will include necessary x-rays allowing us to diagnose the condition of your mouth, teeth and gums. In most instances, your dental condition will be determined at this visit, and if needed, a suitable treatment plan will be discussed with you.

*We appreciate the value of your time, and **except** for emergency situations, you can expect us to be on time with you. We will appreciate the same courtesy. We expect at least 48-hour advance notice for appointment cancellation to allow us to schedule your reserved time to another patient in need.*

Should you have any questions about our practice, services, or policies please do not hesitate to contact us.

Respectfully Yours,

Ilya Sapozhnik, D.D.S.

*Welcome. Thank you for choosing the office of **Dr. Ilya Sapozhnik** for your dental health care needs. If we can be of any assistance to you in completing these forms, please do not hesitate to ask us. Our team is committed to your treatment being both a pleasant and successful experience. Please let us know if there is anything we can do to make your visit with us as comfortable as possible.*

Patient's Name:_____ Date of Birth:_____□ Male □ Female
Last First

If Child: Parent's Name _____

Whom may we thank for this referral:_____

Home Address:_____City: _____State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Fax:_____E-Mail:_____

Patient/Parent Employed By:_____Occupation:_____

Patient/Parent Social Security No:_____

Whom may we contact in case of an emergency?:_____

PRIMARY DENTAL INSURANCE INFORMATION:

Name of Insurance Company:_____Group/Policy #:_____

Name of Subscriber:_____Relationship to the patient:_____

Social Security #:_____Date of Birth:_____Employer:_____

SECONDARY DENTAL INSURANCE INFORMATION:

Name of Insurance Company:_____Group/Policy #:_____

Name of Subscriber:_____Relationship to the patient:_____

GENERAL CONSENT:

I consent to the diagnostic procedures and treatment by Dr. Ilya Sapozhnik necessary for proper dental care.
By signing below I acknowledge that I have received and reviewed a copy of Notice of Privacy Practices and I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. My consent to disclosure of records (or my child's records) shall be effective until I revoke it in writing.I authorize payment directly to the dentist. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. I attest to the accuracy of the information on this page.

PATIENT'S SIGNATURE:_____DATE:_____

We are pleased to welcome you into our practice. So that we may provide you with the best possible care, please complete this dental history form. All information is completely confidential.

Patient's Name:_____

What is the reason for your visit today?_____

Date of Last Dental Visit:_____Last Dental Cleaning:_____Last Full-Mouth X-Rays:_____

What was done at you last dental visit?_____

_____

Previous Dentist's Name:_____Tel:_____

Address:_____City:_____State:____Zip:_____

How often do you have dental examinations?_____

How often do you brush your teeth?_____How often do you floss?_____

Are any of your teeth sensitive to:
Hot or Cold? □ Yes □ No
Sweets? □ Yes □ No
Biting or chewing? □ Yes □ No

Have you noticed any mouth odors or bad breath? □ Yes □ No
Do you frequently get cold sores, blisters, or any other oral lesions? □ Yes □ No
Do your gums bleed or hurt? □ Yes □ No
Have you noticed any loose teeth or change in your bite? □ Yes □ No
Does food tend to get caught in between your teeth? □ Yes □ No

Do you:
Clench or grind your teeth while awake or asleep? □ Yes □ No
Bite your lips or cheeks regularly? □ Yes □ No
Mouth breathe while awake or asleep? □ Yes □ No
Have tired jaws, especially in the morning? □ Yes □ No
Snore or have any other sleep disorders? □ Yes □ No
Do you smoke? □ Yes □ No
Haw many pack(s) per day?___
For how many years?___

Have you ever had:
Orthodontic treatment? □ Yes □ No
Oral Surgery? □ Yes □ No
Your teeth ground or your bite adjusted? □ Yes □ No
A bite plate or mouth guard? □ Yes □ No
A serious injury to the mouth or head? □ Yes □ No
If so, please describe: _____
_____

Have you experienced:
Clicking or popping of the jaw? □ Yes □ No
Pain (joint, ear, side of the face)? □ Yes □ No
Difficulty in opening or closing the mouth? □ Yes □ No
Difficulty in chewing on either side of the mouth? □ Yes □ No
Headaches, neckaches, or shoulder aches? □ Yes □ No
Are you satisfied with your teeth's appearance? □ Yes □ No
Do you feel nervous about having dental treatment? □ Yes □ No
If so, what is your biggest concern? _____
_____
Have you ever had an upsetting dental experience?
If yes, please describe _____

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Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Patient's Name:_____

Primary Care Physician's Name:_____Tel#:_____

Are you under a physician's care now? □ Yes □ No If yes, please explain:_____

_____

Have you ever been hospitalized or had a major operation? □ Yes □ No If Yes, please explain:

_____

Have you ever had a serious head or neck injury? □ Yes □ No If Yes, please explain:_____

_____

Are you taking any medications? □ Yes □ No

Please list names, dosage and
frequency:_____
_____
_____
_____

Do you use controlled substances? □ Yes □ No

Women:
Are you:
Pregnant/Trying to get pregnant? □Yes □No
Taking Oral Contraceptives? □Yes □No
Nursing? □Yes □No

Are you allergic to any of the following?

□Asprin
□Penicillin
□Codeine
□Acrylic
□Metal
□Latex
□Local Anesthetics
□Other _____

Do you have or have you had any of the following? Please circle:

AIDS/HIV positive
Alzheimer's Disease
Anaphylaxis
Anemia
Angina
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
Blood Transfusion
Breathing Problem
Bruise Easily
Cancer
Chemotherapy
Chest Pains
Cold Sores/Fever Blisters
Congenital Heart Disorder
Convulsions
Cortisone Medications
Diabetes
Drug Addiction
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting Spells/Dizziness
Frequent Cough
Frequent Diarrhea
Frequent Headaches
Genital Herpes
Glaucoma
Heart Attack/Failure
Heart Murmur
Pacemaker
Hemophilia
Hepatitis A
Hepatitis B or C
High Blood Pressure
Hypoglycemia
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Pain in Jaw Joints
Parathyroid Disease
Psychiatric Care
Radiation Treatments
Renal Dialysis
Rheumatic Fever
Shingles
Sickle Cell Disease
Sinus Trouble
Stroke
Swelling of the Limbs
Thyroid Disease
Tuberculosis
Tumor / Growths
Ulcers
Venereal Diseases

Have you ever had any serious illness not listed above? □ Yes □ No If Yes, please explain:

_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Patient's Signature:_____Date:_____

HIPAA 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 IF IMPORTANT TO US.

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 about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect (04/14/2003), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes.

You may request a copy of our Notice at any time. For more information about our privacy practices, please contact us.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

Treatment: We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

Payment: We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

Health Care Operations: We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

Appointment Reminders: We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

Treatment Alternatives and Health-Related Benefits and Services: We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

Disclosure to Family Members and Friends: We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

Disclosure to Business Associates: We may disclose your protected health information to our third-party service providers (called, “business associates”) that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

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 to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $50, plus postage if you want the copies mailed to you.

Restriction: You have the right to request that we place additional restrictions on our use or disclose of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended.

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, you may complain to us. You may also 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.

Kindest Regards,

Dr. Ilya Sapozhnik, DDS
2042 Albany Post Road, Suite 3
Croton-On-Hudson, NY 10520
914-734-9557

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

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

Please Print Name:_____

Signature:_____

Date:____ /____/____

OFFICE USE ONLY

We attempted to obtain written acknowledgment 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):_____

_____

Signature:_____