

Buffalo Dental Group LLP

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RECORDS REQUEST

Email: info@thebuffalodentalgroup.com

Requesting Records From (if Buffalo Dental Group, please leave blank)

Office Name _____ **Phone#** _____

Address _____ **City/State** _____

Email _____ **Fax#** _____

Recipient of Records (if Buffalo Dental Group, please leave blank)

Office Name _____ **Phone #** _____

Address _____ **City/State** _____

Email _____ **Fax#** _____

I hereby request and authorize you to release all dental records including radiographs, with the dates they were taken, for the individual named below.

Patient's Name _____ **DOB** _____

Address _____ **City/State** _____

Email _____

Signature of Patient
Or Parent/Guardian _____ ***Date*** _____

We attach record requests out of courtesy; it is the patient's responsibility to get their previous x-rays. If we do not have current X-rays at the initial appointment, we will need to take new X-rays at that appointment. All fees not covered by insurance will be the patient's responsibility.

HEALTH HISTORY

Patient Name: _____

Date of Birth: _____

DENTAL HEALTH HISTORY:

YES NO

YES NO

1. Do your gums bleed when you brush or floss? YES NO
2. Do you experience any teeth sensitivity when eating/drinking? YES NO
3. Do you clench or grind your teeth while awake or asleep? YES NO

4. Are you satisfied with the appearance of your teeth? YES NO
5. Have you ever had Oral surgery or gum treatment in the past? YES NO

MEDICAL HISTORY:

YES NO

YES NO

1. Pharmacy address and phone number: _____

2. Are you currently under the care of a physician? YES NO
3. Date of last physical exam: _____
 Physician: _____
 Physician's Phone No.: _____
4. Do you **PRE-MEDICATE** for dental procedures due to joint replacements or heart related issues? YES NO
5. Have you ever had a serious head, neck, or jaw injury? YES NO
6. Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? YES NO
7. Do you have a history of cocaine or other drug use including marijuana? YES NO

8. Are you **ALLERGIC** to or have you had reactions to:

- | | |
|--|--|
| Local anesthetics like Novocaine? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Penicillin or Amoxicillin? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Sulfa Drugs? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Barbiturates, sedatives or sleeping pills? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Aspirin? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Latex? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Other? _____ | <input type="checkbox"/> YES <input type="checkbox"/> NO |

9. Do you have a history of smoking and/or vaping? YES NO
10. Do you use alcohol? YES NO
11. Do you or a loved one experience snoring that keeps you up at night? YES NO
12. Have you ever or do you currently wear a CPAP? YES NO

Are you taking any medicine(s) including supplements, non-prescription medicine and/or blood thinners? Yes No

If yes, what? (space on back if needed) _____

Do you have, or have you ever had any of the following?

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Pain in Jaw Joints (TMJ) |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Cold Sores/Fever | <input type="checkbox"/> GERD | <input type="checkbox"/> Kidney Problems/Dialysis | <input type="checkbox"/> Parathyroid Disease |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Blisters | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease/Jaundice | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone/Steroid Treatment | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lung Disease/COPD | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Lupus | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Surgery/Disease | <input type="checkbox"/> Mental Health Disorders | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Joint/Implant | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A, B or C | <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Fainting | <input type="checkbox"/> High Cholesterol | | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Spells/Dizziness | <input type="checkbox"/> Hypoglycemia | | |
| <input type="checkbox"/> Cancer | | <input type="checkbox"/> Infective Endocarditis | | |

Have you had any serious illness or major surgeries not listed above? Yes No

If yes, please explain: _____

WOMEN ONLY: Are you: Pregnant/Trying to get pregnant? Taking Oral Contraceptives? Nursing? None

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, as well as for your doctor. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN _____ Date _____

SIGNATURE OF DOCTOR _____ Date _____

PATIENT REGISTRATION

Patient Information

First Name: _____	Last Name: _____	Middle Init: _____
Birthdate: _____	SS#/SIN: _____	Email: _____
Address: _____		City, State, Zip: _____
Home Phone: _____	Work Phone: _____	Cell Phone: _____
Sex: Male Female	Marital Status: Married Single Divorced Separated Widowed	
Emergency Contact: _____		Emergency Contact #: _____ Relationship: _____
How did you hear about us? _____		
Employment Status: Fulltime Part Time Retired N/A	Employer Name _____	
Student Status: Full Time Part Time	School Name: _____	
Previous Dentist: _____	Date of Last Exam: _____	

Responsible Party (If someone other than the patient is being seen today)

First Name: _____	Last Name: _____	Middle Init: _____
Address: _____		City, State, Zip: _____
Home Phone: _____	Work Phone: _____	Cell Phone: _____
Birthdate: _____	Soc. Sec: _____	Email: _____

Primary Insurance Information

Subscriber: _____	Relationship to Subscriber: Self Spouse Child Other
SS #/SIN: _____	Insured Birthdate: _____ Employer: _____
Insurance Company: _____	Insurance active Date _____
Insurance Co. Address: _____ City, State, Zip: _____	
Group#/ Employer _____	Member ID: _____

Secondary Insurance

Subscriber: _____	Relationship to Subscriber: Self Spouse Child Other
SS #/SIN: _____	Insured Birthdate: _____ Employer: _____
Insurance Company: _____	Insurance active Date _____
Insurance Co. Address: _____ City, State, Zip: _____	
Group#/ Employer _____	Member ID: _____

Late Charges/Cancellation Policy

*Balances not paid within 30 days of the billing date may incur a 1.5% monthly late fee where permitted by law. Accounts that remain unpaid may limit future scheduling privileges except for emergencies or prepaid services. In the event collection efforts become necessary, the patient agrees to be responsible for related collection costs and reasonable attorney fees. Appointments are reserved specifically for you to ensure adequate time for your care. We kindly request **at least 48 business hours' notice** for any appointment cancellation or rescheduling. Missed appointments or cancellations without proper notice may result in a **\$100 fee per appointment.***

Patient Signature _____ **Date** _____

Buffalo Dental Group, LLP

**ACKNOWLEDGEMENT OF RECEIPT OF HIPAA
NOTICE OF PRIVACY PRACTICES**

You May Refuse to Sign This Acknowledgment

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

Signature of Patient/Parent/Legal Guardian

Date

Individuals authorized to receive my healthcare information:

Please print name

Please print name

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our HIPAA Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prohibited us from obtaining acknowledgment
- Other (Please Specify)

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 IS 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 **April 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 applicable law permits the changes. 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. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose your health information for different purposes, including treatment, payment and healthcare operations. For example:

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

Payment: We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved in your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection to our healthcare operations. This includes, quality assessment activities, employee review activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may also call you by name in our waiting room when your dentist or hygienist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Your Authorization: In 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. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To You and Your Family: We may disclose your health information to a family member who is responsible to the extent necessary to help with your healthcare or with payment of your healthcare. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity, or an emergency, we will disclose your dental information based on our professional judgement or whether the disclosure would be in your best interest.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your 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 uses 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 involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonable believe that you are a possible victim of abuse, neglect, or domestic violence

Revoke This Authorization: At any time, in writing, you may revoke this authorization, except to the extent that your dentist or dental practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

You have the right to Inspect and copy your protected health Information with limited exceptions. You must make the request in writing. If you request information that we maintain on paper, we may provide photocopies. If you request information we maintain electronically, you have the right to an electronic copy.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

You have the right to request a restriction: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends whom may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

If you have any questions or concerns, please contact us.