Andrew J. Goss, DDS, PLLC.
8302 Provo Dr.
Liverpool, NY 13090

Patient Information Form

Complete all sections

Today's Date: ____/____/____

Patient Name: _____ DOB: ____/____/____ SS# _____-_____-_____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: (_____) _____-_____ Email address: _____
Employer: _____ Work Number: (_____) _____-_____
Whom may we thank for referring you to our office? _____

How will you take care of payments due today? **Cash Check Credit Card Care Credit**

I understand that my deductible and insurance co-payment is expected at the time of service.

Dental History

What is the reason for your visit today? _____
Date of last dental visit? ____/____/____ Last Cleaning: ____/____/____ Last full mouth x-rays: ____/____/____
What was done at your last dental visit? _____
Previous Dentist Name: _____ Phone Number: (_____) _____-_____
Address: _____
How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss your teeth? _____
Do you have any dental problems now? Yes_____ No _____
If yes, please describe:
_____
_____

Have you ever had?
Orthodontic treatment ____
Periodontal treatment ____
Oral Surgery ____

Do your gums bleed or hurt:
Have you ever experienced gum disease or tooth loss? ____
Have you noticed any loose teeth or change in your bite? ____
Does food tend to become caught between your teeth? ____
If yes, where? _____

Are your teeth sensitive to?
Hot or cold ____
Sweets ____
Biting or chewing ____
Have you noticed any mouth odors or bad tastes? ____
Do you frequently get cold sores, blisters or any other lesions? ____

Do you?
Smoke and/or chew tobacco? ____
If yes, how much? ____
How long? ____
When did you quit if you have? ____
Drink alcohol? ____
If yes, how much? ____
How often? ____

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Medical History

Have you been under the care of a medical doctor during the past 2 years? _____
If yes, for what? _____
Physicians Name: _____ _____ Phone Number: (_____) _____-_____
Address: _____
Are you taking any medications? ____
If yes, list the name and dosage: _____
Have you ever had an allergic (or adverse reaction) to any medication or substance? ____
If yes, please list: _____
Do you need to pre-medicate for dental treatment? ____
If yes, for what? _____
What type of antibiotic do you take? _____
Women: Are you pregnant? ____ Months? _____ Are you taking birth control pills? _____

Please indicate which of the following you have had or presently have, circle yes or no for each item:

Heart Surgery, Disease, Attack, Pain….Yes or No
Heart Murmur……..Yes or No
Mitral Valve Prolapse……..Yes or No
Artificial Heart Valve……..Yes or No
High Blood Pressure……Yes or No
Artificial Joints (hip, knee, etc.)……Yes or No
Diabetes……Yes or No
Stroke……..Yes or No
Epilepsy or Seizures……..Yes or No
Arthritis/Rheumatism……..Yes or No
AIDS……..Yes or No
Blood Transfusion……..Yes or No
Hemophilia……..Yes or No
Neurological Disorders……..Yes or No

Chronic Cough……Yes or No
Tuberculosis……Yes or No
Emphysema……Yes or No
Asthma……Yes or No
Latex Sensitivity……Yes or No
Allergies or Hives……Yes or No
Sinus Trouble……Yes or No
Tumors……Yes or No
Radiation……Yes or No
Chemotherapy……Yes or No
HIV Positive……..Yes or No
Hepatitis A or B……Yes or No
Contact Lenses……Yes or No

Do you have or have you had any disease, condition or problem not listed? _____ If yes, please list:
_____
_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of any changes in my health or medication.

Signature: _____ Date: ____/____/____

History Review:
Dentist Signature: _____ Date: ____/____/____

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All sections must be completed

Patient Name: _____ **(please print)**

Financial Statement

The following Financial Policy is required prior to any dental treatment. Please understand we do not want financial constraints and/or broken appointments to interfere with your dental care and our provider/patient relationship. To facilitate your payments, the following options are listed. Please read them carefully, **initial and sign all designated lines**.

Name of person who guarantees account: _____ **(Please Print)**
Signature of person who guarantees account: _____
Relationship to Patient: _____

Please complete the following if account is guaranteed by someone other than patient

Address of Guarantor: _____
_____
Guarantor's Social Security Number:_____-_____-_____

Guarantor's Phone Number: (_____) _____-_____
Guarantor's Date of Birth: _____/_____/_____

Payment Options

IF YOU DO NOT HAVE INSURANCE, we will give you a 10% discount for paying your full balance on the day of service. For your convenience, we accept cash, check, MasterCard, Visa, Discover, American Express and Care Credit. Any balance that exceeds ninety (90) days will have a 1.5% finance charge added for every thirty (30) day period carrying a past due balance. _____ **(initial)**

IF YOU HAVE INSURANCE, a 10% discount will be given to all patients paying your full balance on the day of service. You also have the option of assigning insurance payments to our office and being billed for the remainder upon our receipt of the insurance payment. We will submit your insurance claim to your insurance carrier as a courtesy to you. The amount of coverage paid by your insurance carrier may be based on **your insurance company's Usual and Customary Rates and/or Fee Schedule.** If your insurance carrier only pays the patient directly, you will be responsible for turning that check over to Dr. Goss. You will also be responsible for any portion of your balance not paid by your insurance company. Any balance that exceeds ninety (90) days will have a 1.5% finance charge added for every thirty (30) day period carrying a past due balance. _____ **(initial)**

I understand that my deductible and insurance co-payment is requested at the time of service.

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Broken Appointment Policy

Appointments in our office are reserved exclusively for each patient and are also customized according to the individual needs. For this reason, if you are unable to keep your reserved appointment, please give the office at least a **24 HOUR NOTICE.** A $25.00 fee may be charged for appointments broken without notice. _____ **(initial)**

Collection Policy

All accounts more than ninety (90) days past due are subject to referral to a collection agency. _____ **(initial)**

Additional Costs

I understand and agree to pay for **ALL** costs involved with a collection agency, small claims court and/ or attorney's fees if my account is not paid in full. _____ **(initial)**

Returned Checks

There will be a $50.00 returned check fee applied to your account if a check is returned. The account then must be paid by Cash or Credit. _____ **(initial)**

_____ **(Signature)** ___/___/___
Patient/Parent or Legal Guardian Date

_____ ___/___/___
Doctor Signature Date

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I _____ (Please Print Name) understand that Dr. Goss is an "**out of network**" provider for **ALL** dental insurances. I understand that this means I will be responsible for all costs associated with my treatment ***if*** my dental insurance does not pay for services rendered by "**out of network providers**".

Note: Most insurance allows you to see out of network dentists.

If you are unsure of whether or not your coverage extends to out of network dentists, please let us know. We are happy to verify your coverage before you incur charges.

_____ ____/____/____
Patient/Parent of Guardian Signature Date

_____ ____/____/____
Andrew J. Goss Date

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Consent for Dental Treatment

Patient Name: _____ DOB: ____/____/____ Chart Number: _____

1. I hereby authorize Andrew J. Goss, DDS, and whomever he designates as a dental hygienist or dental assistant to perform upon the following invasive procedures or operations by their licensure/designation:
   - -Dental, intraoral and extra-oral head and neck exams
   - -Dental radiographs and intraoral imaging
   - -Preventive hygiene therapy including fluoride treatments
   - -Evacuation and restoration of dental carries
   - -Correction of missing teeth with removable or fixed prosthesis
   - -Cosmetic correction of misshapen, misaligned or discolored teeth
   - -Dental Implants
   - -Dental Extractions
   - -Periodontal procedures
   - -Endodontic procedures
   - -TMJ, tooth grinding and other protective therapies
   - -Other procedures within the scope of the dental practice to meet specific dental needs not addressed above

2. The procedure (s) necessary to treat my condition (s) have been explained to me and have been documented. Alternative types of treatment have also been explained to my satisfaction.

3. Both the risks and benefits of the preferred and alternative treatment plans have been explained to my satisfaction. Further, Dr. Goss has explained the risks of not having treatment done in a timely manner. I understand these risks may include but are not limited to: dental infections, dental decay, gingival infection, tooth loss, dentofacial discomfort and the loss of chewing function.

4. Additionally, I consent to the administration of local anesthesia as deemed necessary by Dr. Goss. I further understand that there are risks associated with the administration of local anesthesia. These have been explained to my satisfaction and I understand they include but are not limited to: nerve injury causing temporary or permanent numbness, infection, bruising and stiffness of the jaw muscles.

5. I understand that a perfect result cannot be guaranteed or warranted. I have been given the opportunity to ask questions about my dental conditions and needs to my satisfaction and I believe I have sufficient information and understand to consent to treatment.

Patient or legal guardian: _____ Date: ____/____/____
State relationship if legal guardian: _____

Dentist: _____ Date: ____/____/____

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Authorization for Use and Disclosure of Health Information

Patient Name: _____ DOB: ____/____/____ Chart Number: _____

It is our intent to protect the confidential nature of your protected healthcare information. Personal and clinical information are not given to vendors or other institutions without your expressed knowledge of such as follows.

Please review and initial the following releases of Protected Healthcare Information:

1. Permission to use postcards to confirm time and date of dental appointment: **Yes___ No___**

2. Permission to leave appointment confirmation on voicemail systems and answering machines at the telephone number (s) you have provided, including necessary pre-medication: **Yes___ No___**

3. Permission to confirm appointments with family members or other individuals that may answer your phone: **Yes___ No___**

4. I hereby authorize Dr. Goss or a member of his staff to send out claims to my insurance company for services rendered and I agree to be responsible for all charges for dental services and materials not paid by the insurance company: **Yes___ No___**

5. I authorize the release of any information relating to the contents of my medical/dental records to physicians, dentists or other medical specialists for the purposes of referral or consultation regarding a specific dental or medical attention: **Yes___ No___**

6. I acknowledge that this office uses a collection agency in the event of failure of the patient to meet their financial obligations in the agreed upon time frame.

Patient or Legal Guardian: _____ Date: ____/____/____
State relationship if Legal Guardian: _____

Note: As the parent or legal guardian, I hereby authorize the following individuals to bring my child/children to this office for dental care:

_____
_____

Dentist: _____ Date: ____/____/____

Notice of Privacy Practices Consent Form

By Signing below, I acknowledge I have read and understand the information regarding the use and disclosure of my protected health information.

Signature: _____

Date: ____/____/____

NOTICE OF PRIVACY PRACTICES
(DENTAL)

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care options.

·**Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
·**Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
·**Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

·The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do not agree to a restriction, we must abide by it unless you agree in writing to remove it.
·The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
·The right to inspect and copy your protected health information.
·The right to amend your protected health information.

·The right to receive an accounting of disclosures of protected health information.
·The right to obtain a paper copy of this notice from us upon request.

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

This notice is effective as of August 8, 2011 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice of the policies and procedures of our office. We will not retaliate against you for filling a complaint.

Please contact us for more information:

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Ave, SW
Washington, DC 20201
(202)619-0257
Toll Free: 1-877-696-6775

Privacy Officer
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