

WELCOME

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.

1 Personal Information

Name _____ Soc. Sec.# _____
Last name First Name Initial

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced Dependent Minor

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

2 Dental Insurance Information

Primary Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

SS#/SIN _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group # _____

Employee/Cert.# _____

Ins. Co. Address _____

Deductible _____

Amount already used _____

Max. annual benefit _____

Additional Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

SS#/SIN _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group # _____

Employee/Cert.# _____

Ins. Co. Address _____

Deductible _____

Amount already used _____

Max. annual benefit _____

3 Authorization and Release

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 other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X
Signature of patient or parent/guardian if minor

Date _____

4 Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad breath | <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting |
| <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot | <input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth |

5 Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? Y N

If yes, describe _____

Are you currently under physician care? Y N If yes, describe _____

Have you ever had blood transfusion? Y N If yes, describe _____

Have you ever taken Fen-Phen/Redux? Y N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. Y N

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check (✓) yes or no if you have had problems with any of the following:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive | <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis | <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Material allergies – latex, wool, metal, chemicals | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints | <input type="checkbox"/> Y <input type="checkbox"/> N Food Allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/ Heart surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone) | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or malfunction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease | <input type="checkbox"/> Y <input type="checkbox"/> N Heart problems | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | Describe _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes | | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure | | |

Is patient currently taking any medications? If yes, list all:

Does patient have drug allergies? If yes, list all:

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 2.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). Delinquent accounts may require a pre-payment or credit card on file for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask – we are always happy to help.

NOTICE OF PRIVACY PRACTICES

Protecting Your Confidential Health Information Is Important To Us

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.

Our Promise

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA—Health Insurance Portability And Accountability Act) enacted to protect the confidentiality of your health information. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting health care operations, and as otherwise described in this notice.

How your HEALTH INFORMATION may be used To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with dental care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interests.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

The logo for MaxDental features a stylized blue outline of a tooth on the left, followed by the word "MaxDental" in a blue, cursive script font.

DR. MICHAEL MAKSYMIUK

151 OLD RIDGEFIELD RD. WILTON, CT 06897

PHONE 203-762-9480

EMAIL contactus@maxdental.org

Protecting Your Confidential Health Information is Important to Us

Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert A Serious Threat To Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

To The U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death Or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgment

Patient Name(s): _____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

Patient Signature

Date _____ / _____ / _____

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

Effective Date: _____

PATIENT RIGHTS

You have the following rights related to your health information.

Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or health care operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a health care item or service for which you have paid us out-of-pocket in full.

Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice. *You have the right* to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.



Dr. Michael Maksymiuk, D.M.D

151 Old Ridgefield Road

Wilton, CT 06897

203-762-9480

OFFICE POLICIES

As a courtesy to our patients, we will submit all dental insurance claims, provided that we have all required information. Our staff will try to help with any of your insurance needs or questions. **Pre- estimates will be sent to insurance at the request of the patient; we do ask that you allow at least 30 days before your scheduled treatment for the pre-estimate to be processed.** It is your responsibility to inquire about your coverage with your insurance company, and to keep our office updated with any changes to your insurance coverage. Please remember, **YOU ARE FINANCIALLY RESPONSIBLE FOR YOUR ACCOUNT, REGARDLESS OF INSURANCE.**

All payments are due on the date services are rendered. We accept all major credit cards, check and cash payments. All billing statements are due upon receipt; balances unpaid after **30 days** are subject to a **2.5% finance charge per month**. To avoid finance charges, we recommend keeping a credit, debit or healthcare card on file. Credit cards on file are processed after insurance has paid.

Accounts over 90 days will be sent to collections. Any account sent to collections will not be permitted to schedule appointments until balance is paid in full. Patients who have been in collections are required to keep a credit card on file to be billed on the date of service, or after insurance has paid. **Any accounts sent to collections will be subject to termination from the practice.**

Returned checks are subject to a \$25.00 service charge. Any account with a returned check will not be permitted to schedule any appointments until balance and fees are paid. Returned check fee payments can only be paid by cash, credit card, or certified check. **Accounts with unpaid returned check fees over 30 day will automatically be sent to collections.** MaxDental reserves the right to suspend or revoke a patient's check-writing privileges, if the account indicates a history of returned checks.

Please respect our commitment to excellence in Dental Care by being on time for your appointments. These hours are in demand and missed appointment without **48 hours notice** prevents someone else from receiving needed care. We try to confirm all appointments in advance, however at times we may be unable to reach you directly. It is your responsibility to keep your appointments. **We require at least 48 hours notice to avoid broken appointment charges (please reference our cancelation policy).** We will make every effort to assist you in providing an appointment time convenient to your schedule; please help us by maintaining your commitment to your dental health. Thank you.

I have read the above office policies and have received a copy for my records.

Signature _____ Date _____

EFFECTIVE JANUARY 1, 2019
CANCELLATION AND BROKEN APPOINTMENT POLICY

We understand that illness, emergencies, flat tires and bad weather do occur. We ask our patients to give us 48 hours' notice whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

Policy and Fees:

Cancellation or rescheduling of an appointment with **48 hours or more** notification- **no charge**
Cancellation or rescheduling of an appointment **less than 48 hours and up to 24 hours** may or may not be considered a broken appointment; it will be at our discretion.

Failure to give 24 hour advance notice:

\$50 for hygiene appointment

\$95 for a doctors' appointment

- Definition of a "**Broken Appointment**": is when you

Cancel or Reschedule an appointment with less than 24 hour notice

Do not show up for the scheduled appointment

Our number one concern is our patients' dental health. Providing services in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing adequate notice, this adds to the overall cost of care, as trained professionals and dental facilities are not being utilized.

We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask us at *MaxDental*.

Thank you
Dr. Michael Maksymiuk
And Staff

Signature _____ Date _____