Mark Sawycky, DDS
10 Garrett Place
Carmel, New York 10512
1-845-225-7733
Frontdesk@sawyckydds.com

Dear Patient,

On behalf of all my staff, I welcome you to our office. We are pleased that you have selected us to care for your dental needs. 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.

Enclosed are several forms for you to fill out at your convenience. They include a medical questionnaire and a notice of privacy practices. Please bring the **completed forms** along with your **insurance card** to your first visit. We currently have a contract with Delta Dental, Cigna & United Healthcare. Please be aware that participation in these insurances does not guarantee no out-of-pocket cost. For all other insurance companies, our office will submit your claims at each visit and any difference between our fees and the insurance payment will be billed to you.

During your first visit, a thorough examination will be completed. This exam will include necessary X-rays as well as the use of other aids which may be necessary to make an accurate diagnosis of the condition of your mouth, teeth, and gums. Your dental condition can then be adequately determined and a suitable treatment plan will be discussed with you. In most instances, a cleaning and polish is also performed at this visit. If you have had any **DENTAL X-RAYS taken in the last 12 months**, please have them emailed to us at **Frontdesk@sawyckydds.com.**

We appreciate the value of your time and, except for emergency situations, you can expect us to be on time for you. We would appreciate the same courtesy. In canceling or rescheduling an appointment, kindly give 24-hour advance notice so that your time may be given to another patient.

We look forward to a relaxed and pleasant visit with you.

Sincerely,

Mark Sawycky, DDS

Welcome!

REGISTRATION FORM

Section I: Patient Information Date_____

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Last Name:_____ First Name:_____ MI:___ Preferred Name: _____

Address:_____City:_____State:_____Zip_____

Home Phone (____)_____ Work Phone (____) _____ Cell Phone (____)_____

Date of Birth:_____ Social Security Number:_____ Gender: ☐ M ☐ F

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Email Address:_____ Would you like appointment confirmations via e-mail? ☐ Yes ☐ No

Emergency Contact:_____Phone:_____Relation:_____

Whom may we thank for referring you? _____

Section II Who Will Be Responsible for Your Account

Skip this section, if same as above.

Name:_____ Relationship to Patient: _____

Address:_____

City:_____ State:_____ Zip:_____ Phone: (____)_____

Employer_____ Work Phone (____)_____

SSN#_____

Section III Insurance Information

Name of Subscriber_____DOB_____Relationship to Patient _____

SSN#:_____ Name of Employer:_____

Insurance Company_____ Grp #_____ ID#_____

Ins Co Address:_____ Ins Co. Phone:_____

---------- DO YOU HAVE SECONDARY INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ---------

Name of Subscriber_____DOB_____Relationship to Patient _____

SSN#:_____ Name of Employer:_____

Insurance Company_____ Grp #_____ ID#_____

Ins Co Address:_____ Ins Co. Phone:_____

MEDICAL HISTORY

Last Name:_____ **First Name:**_____

Please answer ALL of the following questions. Your answers are completely CONFIDENTIAL. This information is important in order to treat you safely and efficiently. Information that is left out or incorrect can be dangerous to your health. Please feel free to discuss any questions or extenuating circumstances with the doctor.

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?			
Damaged / Replaced / Artificial heart valves? (Circle one)	☐ Yes	☐ No	
Heart trouble inc. rheumatic heart disease?	☐ Yes	☐ No	Describe:
Surgical implants or artificial joints?	☐ Yes	☐ No	What kind? When placed?
Premedication for dental treatment?	☐ Yes	☐ No	Name of medication:
Hepatitis A, B, C, D? (Circle letter)	☐ Yes	☐ No	When?
Jaundice or liver disease?	☐ Yes	☐ No	When?
Kidney disease or trouble?	☐ Yes	☐ No	
Stomach ulcers?	☐ Yes	☐ No	
Tuberculosis (TB)?	☐ Yes	☐ No	When?
Coughing up blood?	☐ Yes	☐ No	
Blood disorders?	☐ Yes	☐ No	What kind?
Bruise easily?	☐ Yes	☐ No	
Low blood pressure?	☐ Yes	☐ No	
High blood pressure?	☐ Yes	☐ No	
Surgery within the past 5 years?	☐ Yes	☐ No	What for?
Cancer?	☐ Yes	☐ No	What kind? When?
Radiation or chemotherapy? (Circle one or both)	☐ Yes	☐ No	When?
Sinus trouble?	☐ Yes	☐ No	
Hives or skin rash?	☐ Yes	☐ No	What causes it?
Allergies to medication, anesthetic or food?	☐ Yes	☐ No	Name?
Asthma?	☐ Yes	☐ No	
Hay fever or seasonal allergies?	☐ Yes	☐ No	
Fainting spells or dizziness?	☐ Yes	☐ No	
Diabetes?	☐ Yes	☐ No	When diagnosed?
Arthritis or rheumatism?	☐ Yes	☐ No	
Mental condition or disorder?	☐ Yes	☐ No	What kind?
Seizures or epilepsy?	☐ Yes	☐ No	Date of last seizure?
Sexually transmitted disease?	☐ Yes	☐ No	What kind?
HIV infection?	☐ Yes	☐ No	When diagnosed?
Are you pregnant?	☐ Yes	☐ No	Which month?
Are you nursing?	☐ Yes	☐ No	
Smoking habit?	☐ Yes	☐ No	How many pack/day? For how many years?
Smokeless or chewing tobacco?	☐ Yes	☐ No	
Do you use recreational drugs, inc. alcohol?	☐ Yes	☐ No	Name? How often?

MEDICAL HISTORY

Last Name:_____ **First Name:**_____

Do you have any disease, condition or problem not listed above that you think your dentist should know about?_____

_____

Please list any medications that you are taking **(include birth control & vitamins):**

_____

_____

_____

_____

Have you ever had trouble with previous dental treatment or oral surgery? Please describe.

_____

_____

Name & Address of **Medical** Dr: _____ Preferred Pharmacy:_____

_____ _____

_____ _____

I authorize the release of my medical records to this office, if necessary, and grant the right to the dentist to release health information obtained from me, and information about my dental treatment to Third Party Payors and/or other health care practitioners. I certify that I have read and understand the above questions. I acknowledge that my questions, if any, about the questions set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his staff, responsible for any errors or omissions that I may have made in completing this form.

Date:_____ Patient's (or Parent/Guardian's) Signature:_____

Dentist's Signature:_____

DENTAL HISTORY

Last Name:_____ **First Name:**_____

What is the reason for your dental visit today?_____

When was your last dental visit to the dentist (if to a different office)?_____

What was done on your last dental visit (if to a different office)?_____

Have you ever had a trouble with previous dental treatment or oral surgery? Please explain._____

_____

Prior dentist's name & address: _____

_____

How frequently do you brush your teeth? ☐ 3+ a day ☐ Twice a day ☐ Once a day ☐ Weekly ☐ Seldom

How frequently do you floss your teeth? ☐ 1+ a day ☐ 2-6 weekly ☐ 1-6 monthly ☐ Seldom ☐ Never

Do your gums bleed when you brush or floss?	☐ Yes ☐ No
Do your teeth experience sensitivity to cold or hot temperatures?	☐ Yes ☐ No
Are any of your teeth currently causing you pain?	☐ Yes ☐ No
Do you grind your teeth (either consciously or during sleep)?	☐ Yes ☐ No
Are any of your teeth loose?	☐ Yes ☐ No
Do you currently have any dental implants, dentures or partials?	☐ Yes ☐ No

If you could change anything about your mouth, teeth, or smile, what would it be?

_____

_____

Patient signature:_____

NOTICE OF PRIVACY PRACTICES

Protecting Your Confidential Health Information is Important to Us

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 is not meant to alarm you! Quite the opposite!
It is our desire to communicate to you that we are taking seriously the federal law (HIPAA – Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

Why have a privacy policy? Very good question!

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.

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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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an Electronic or Paper Copy of Your Medical Record
You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you, and we will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask Us to Correct Your Medical Record
You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we will tell you why in writing within 60 days.

Ask Us to Limit What We Use or Share
You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Accounting of Disclosures of Your Health Information to Receive a List of Those Whom We've Shared Information
You have the right to ask us for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all disclosures except for those about treatment, payment, and health care operations and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Obtain a Copy of This Privacy Notice
You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose Someone to Act on Your Behalf
If you give someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a Complaint if You Feel Your Rights Are Violated
You can complain if you feel we have violated your rights by contacting us using the information on page I. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

Your Choices
For certain health information, you can tell us your choices about what we can share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Include your information in a hospital directory

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Family, Friends and Caregivers
We may share your health information with those you tell us will be helping you with your 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.

Authorization to Use or Disclose Health Information
We are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your Protected Health Information (PHI) for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

NOTICE OF PRIVACY PRACTICES

Other Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat You
We can use your health information and share it with other professionals (for example, pharmacies or other health care personnel who are treating you).

Run Our Organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary. For example, we use your health information to manage your treatment and services.

Bill For Your Services
We can use and share your health information to bill and get payment from health plans and other entities. For example, we give information about you and your health insurance plan so it will pay for your services.

How Else Can We Use or Share Your Health Information?
We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: *www.hhs.gov/ocr/privacy/hipaaunderstanding/consumers/index.html*.

In Patient Reminders
Because we believe regular care is very important to your 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 care. 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.

To Avert a Serious Threat to Health or Safety
We may disclose your health information to reduce a risk of serious and imminent harm to another person or to the public including preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence as well as preventing or reducing a serious threat to anyone's health or safety.

Help With Public Health and Safety Issues
We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect or domestic violence and preventing or reducing a serious threat to anyone's health or safety.

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 interest.

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

Comply With the Law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to Organ and Tissue Donation Requests
We can share health information about you with organ procurement organizations.

Work With a Medical Examiner or Funeral Director
We can share information with a coroner, medical examiner, or funeral director when an individual dies.

Address Workers' Compensation, Law Enforcement, and Other Government Requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

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

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.

To The U.S. Department of Health and Human Services (HHS)
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to Lawsuits and Legal Actions
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.

Our Responsibilities

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We are required by law to maintain the privacy and security of your protected health information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Notice

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 our patients receive a copy of the revised Notice.
Effective Date: 9/01/23

Patient Acknowledgement

Date:_____
Patient Name(s)_____
Patient Signature_____

Thank you very much for taking the 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 greatly appreciate your acknowledging the receipt of our policy by signing this form. For additional information about the matters discussed in this notice, please contact our Privacy Officer.