STEVEN R. SCHWARTZ, DDS
NY Oral & Maxillofacial Surgeon, P.C.

Patient Registration / Medical History
(Please Print)

Date_____ Cell Phone_____ Home Phone_____

Patient_____
Last Name First Name Initial E-mail Address

Street Address_____
Street Address City State Zip Code

Sex: ❑ Male ❑ Female Age_____ Birthdate_____ ❑Single ❑Married ❑Widowed ❑Separated ❑Divorce

Name of General Dentist_____ Date of Last Visit_____

Physician's Name_____ Date of Last Physical _____

Are you currently under the care of a physician?_____

If so, what is the condition being treated_____

Has there been any change in your general health within the past year? ❑Yes ❑No

Have you had any serious illness or operation?❑Yes ❑No Have you been hospitalized within the past 5 years? ❑Yes ❑No

If so, what was the illness or operation _____

Do you have or have you had any of the following diseases or problems (check all boxes either yes or no)

YES	NO		YES	NO		YES	NO	
❑	❑	Heart Murmur	❑	❑	Headaches	❑	❑	Swollen Neck Gland
❑	❑	High Blood Pressure	❑	❑	Hepatitis, Jaundice or Liver Disease	❑	❑	Rheumatic Fever
❑	❑	Low Blood Pressure	❑	❑	Cancer	❑	❑	Sinus Problem
❑	❑	Circulatory Problems	❑	❑	Psychiatric Care	❑	❑	AIDS/HIV
❑	❑	Nervous Problems	❑	❑	Mitral Valve Prolapse	❑	❑	Thyroid Disease
❑	❑	Radiation Treatment	❑	❑	Allergies to Anesthetics	❑	❑	Stroke
❑	❑	Artificial Heart Valves or Joints	❑	❑	Allergies to Medicine or Drugs	❑	❑	Stomach Ulcer
❑	❑	Recent Weight Loss	❑	❑	General Allergies	❑	❑	Venereal Disease
❑	❑	Back Problems	❑	❑	Blood Disease	❑	❑	Chemical Dependency
❑	❑	Diabetes	❑	❑	Arthritis	❑	❑	Hemophilia
❑	❑	Respiratory Disease/Asthma	❑	❑	Congenital Heart Lesions	❑	❑	Tuberculosis
❑	❑	Glaucoma	❑	❑	Inflammatory Rheumatism	❑	❑	Kidney Trouble
❑	❑	Persistent Cough or Cough Up Blood						
❑	❑	Epilepsy or Fainting Spells	❑	❑	Special Diet			
❑	❑	Cardiovascular Disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, arteriosclerosis)						

Have you had abnormal bleeding associated with previous extractions, surgery or trauma? ❑Yes ❑No

Have you ever required a blood transfusion? ❑Yes ❑No If so, explain_____

Do you have any blood disorders, such as anemia? ❑Yes ❑No

Have you had surgery or x-ray treatment for tumor, growth, or other condition of your mouth or lips? ❑Yes ❑No

Are you currently taking any drugs or medicine? ❑Yes ❑No If so, what_____

_____

_____

Are you **now** taking or have you taken any of the following in the **past year**?

Nitroglycerin ❑Yes ❑No Anticoagulants (blood thinners) ❑Yes ❑No Steroids (Cortisone) ❑Yes ❑No

Tranquilizers ❑Yes ❑No High blood pressure medication ❑Yes ❑No Bisphosphonates (Fosomax) ❑Yes ❑No

Antihistamines ❑Yes ❑No Insulin, Tolbutamide or similar drugs ❑Yes ❑No Digitalis or drugs for heart trouble ❑Yes ❑No

Are you allergic or have you reacted adversely to any medicines or drugs ❑Yes ❑No If so, explain _____

_____

Do you smoke? ❑Yes ❑No ____per day for_____years Alcohol consumed: daily ____ weekly _____ monthly_____

Do you have any disease, condition, or problem not listed above ❑Yes ❑No If so, explain _____

_____

WOMEN: Are you pregnant? ❑Yes ❑No Are you taking oral contraceptives (birth control pills) ❑Yes ❑No

Are you breast feeding? ❑Yes ❑No Do you have any problems associated with your menstrual period? ❑Yes ❑No

MEN: Prostate gland problems ❑Yes ❑No

I certify that the above information is true and accurate, and that there have been no omissions for my medical history. I consent to the taking of clinical photographs in the course of diagnostic and surgical procedures for use for treatment, educational or research purposes. I authorize the release of any medical or other information necessary to process insurance claims and authorize payment of benefits to the treating dentist for the services provided. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature_____ Date_____

STEVEN R. SCHWARTZ, DDS
NY Oral & Maxillofacial Surgeon, P.C.

Patient Contact/ Financial and Insurance Information (Please Print)

Patient Social Security #_____ Spouse/Parent Social Security #_____

Who is responsible for this account?_____ Relationship to Patient_____

Patient Employed By _____Occupation _____

Business Address_____ Business Phone_____

Spouse/Parent Name_____ Spouse/Parent Birthdate_____

Spouse/Parent Employed By_____ Email Address_____

Business Address_____ Business Phone_____

Name of Primary Dental Insurance Company_____ Group Number_____

Name of Primary Medical Insurance Company_____ Group Number_____

Primary Insured Name_____ Insured's Birthdate_____

Insured Employed By_____ Occupation_____

Business Address_____ Business/Cell Phone_____

Secondary Insured Name_____ Insured's Birthdate_____

Insured Employed By_____ Occupation_____

Business Address_____ Business/Cell Phone_____

In case of emergency, who should be notified?_____ Relation_____

Contact's Address_____ Contact's Phone Numbers_____

FINANCIAL POLICY: Full payment is expected on the day of surgery or consultation. We offer the following payment options. Please place a checkmark beside the option(s) you wish to use.

❑ Cash ❑ Personal Check ❑ VISA/MC/DISC/AMEX ❑ Debit Card ❑ Springstone/ Citibank

On your statement, amounts owed by you (not covered by insurance) are listed as amounts due. A 1.5% (APR18%) finance charge is applied to any amount due carried beyond 30 days. The minimum monthly finance charge is $5.00.

I agree, that in the event any amount due for services rendered from the date of billing are referred to an agency or attorney for collection, I shall be responsible for and pay any and all costs associated with such collection costs including court costs and reasonable attorneys' fees in such amounts as may be fixed by the court plus interest. All amounts remaining unpaid following thirty (30) days from the date of billing shall accrue interest at the highest statutory rate from and after the date of billing.

INSURANCE POLICY: No insurance company will cover 100% of all dental/medical expenses. We can only estimate insurance payments. We do our best to collect from insurance carriers on your behalf, but you are responsible for the unpaid balance. Should your insurance company pay more than we estimate, we will send you a refund. If your insurance company pays less than we estimate, we will send you an itemized bill. Insurance coverage is not a reliable indication of the most appropriate treatment. This is a matter best decided between you and the doctor.

I agree that all dental and medical insurance policies are an arrangement between an insurance carrier and myself. I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment, regardless of my insurance company's determination.

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold Dr. Steven R. Schwartz or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

Please sign below to indicate that you understand and accept the above information and policies.

_____ _____

Signature Date

Dr. Steven R. Schwartz
NY Oral & Maxillofacial Surgeon, PC

Pharmacy Form

As per the new 2016 Public Health Law, New York State now requires all practitioners to electronically prescribe all prescription medications. Please fill out the **PHARMACY** information below so that we can comply with this new regulation. This will allow us to email your prescriptions to your pharmacy of choice.

Pharmacy name:

_____

Pharmacy address:

_____

Pharmacy zip code:

_____

Pharmacy phone number:

_____

Dr. Steven R. Schwartz
NY Oral & Maxillofacial Surgeon, PC

Photographic Consent/Release

I hereby give Dr. Steven R. Schwartz of NY Oral & Maxillofacial Surgeon, PC (herein after referred to as Dr. Schwartz) the absolute and irrevocable right and permission, with respect to the photographs that have been taken of me by Dr. Schwartz and his employees, in which I may be included alone or with others:

a. **To copyright the same in Dr. Schwartz's name or in any other name that Dr. Schwartz may choose.**

b. **To use, re-use, publish and re-publish the same in whole or in part, individually or in conjunction with other photographs or other printed materials, in any medium and for any purpose whatsoever, including (but not by way of limitation) illustration, promotion, advertising and trade.**

c. **To use my name in connection therefore if Dr. Schwartz so chooses.**

I hereby release and discharge Dr. Schwartz from any and all claims and demands arising out of or in connection with the use of the photographs, including any and all claims for libel.

This authorization and release shall also ensure to the benefit of the legal representatives, licensees and assigns of Dr. Schwartz as well as, any person(s) for whom Dr. Schwartz took the photographs.

I am over the age of eighteen. I have read foregoing and fully understand the contents thereof.

SUBJECT:

Signed: _____

Print Name: _____

Date: _____

Effective: September 23, 2013

NOTICE OF PRIVACY PRACTICES

HIPAA Form
(Please Print)

Steven R. Schwartz, DDS
NY Oral & Maxillofacial Surgeon, P.C.
2844 Ocean Parkway Ste. B2 Brooklyn, NY 11235-7901
Tel. *718-946-6600* Fax *718-996-2261*
office@nyomsurgeons.com
Contact person: Beth Katz

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth, mouth, and oral health; prescribing medications and faxing them to be filled; prescribing dental appliances and dental prostheses; showing you treatment options; referring you to another dentist for specialty care; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your dental or medical care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, [we will] [we usually will not] ask you for special written permission.

We will ask for special written permission in the following situations: anything related to HIV/AIDS status, any sale of information, any use of information for marketing or fundraising purposes.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. We must honor a restriction not to send information to a health care plan regarding any service for which you have already made full payment. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 10 days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- be notified by us in a timely manner of any breach of the privacy and confidentiality of your unsecured protected health information, which we will provide to you in accordance with law and take all appropriate measures to address.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

STEVEN R. SCHWARTZ, DDS
NY Oral & Maxillofacial Surgeon, P. C.

HIPAA Consent
(Please Print)

Acknowledgement of Receipt of Notice of Privacy Practices

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

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

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

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