WESTCHESTER PUTNAM ENDODONTIC ASSOCIATES, P.C.

101 S. Bedford Road, Mt. Kisco, NY 10549 • (914) 241-1177
99 Gleneida Avenue, Carmel, NY 10512 • (845) 225-2717
77 Quaker Ridge Road, New Rochelle, NY 10804 • (914) 636-4343
40 East Putnam Avenue, Cos Cob, CT 06807 • (203) 625-7686

DATE _____

Patient Information – Please Print And Fill Out COMPLETELY

☐ MISS ☐ MRS. ☐ MS. ☐ MR. ☐ DR. ☐ OTHER

_____
(FIRST) (MIDDLE) (LAST)

HOME TEL. #_____ WORK # _____ CELL #_____

ADDRESS _____
STREET TOWN STATE ZIP

EMAIL ADDRESS _____

SOCIAL SECURITY #_____ DATE OF BIRTH _____

WHO REFERRED YOU TO OUR OFFICE _____

Pharmacy Information

PHARMACY NAME_____ TEL. #_____

LOCATION _____
STREET TOWN STATE ZIP

Payment Information For Dependent

PERSON RESPONSIBLE FOR FINANCES_____

RELATIONSHIP TO PATIENT _____

HOME #_____ WORK # _____ CELL #_____

ADDRESS _____
STREET TOWN STATE ZIP

SOCIAL SECURITY #_____ DATE OF BIRTH _____

Payment is expected at the time services are rendered. For your convenience, we accept Visa, Mastercard, or American Express, as well as cash or check. We also offer CARECREDIT which allows for payments on a monthly basis. Ask a receptionist for details.

Please understand that we do not participate in any insurance plans. Upon completion of treatment, as a courtesy to you, we will submit your insurance claim for your reimbursement provided we have all the necessary insurance information.

Please Complete All Medical Questions On Reverse Side

MEDICAL HISTORY

1. WHAT IS YOUR PRESENT HEALTH STATUS? _____

2. HAVE YOU RECENTLY BEEN UNDER MEDICAL TREATMENT, IF YES, EXPLAIN _____

_____

3. HAVE YOU EVER BEEN INFORMED THAT YOU HAD:

	YES	NO		YES	NO		YES	NO
1. HEART AILMENT	____	____	7. LIVER DISEASE/HEPATITIS	____	____	13. TUMORS OR GROWTHS	____	____
2. RHEUMATIC FEVER	____	____	8. HIV/AIDS	____	____	14. KIDNEY DISEASE	____	____
3. MITRAL VALVE PROLAPSE	____	____	9. BLOOD DISEASE	____	____	15. THYROID DISEASE	____	____
4. HIGH/LOW BLOOD PRESSURE	____	____	10. ANEMIA	____	____	16. ARTHRITIS	____	____
5. TUBERCULOSIS	____	____	11. DIABETES	____	____	17. STOMACH OR INTESTINAL DISEASE	____	____
6. LUNG DISEASE	____	____	12. GLAUCOMA	____	____			

EXPLAIN YES ANSWERS _____

_____

_____

4. ARE YOU PRESENTLY TAKING ANY MEDICATION ? _____ PLEASE LIST AND DESCRIBE FOR WHAT MEDICAL CONDITION

_____

_____

5. DO YOU NEED TO PRE-MEDICATE PRIOR TO DENTAL TREATMENT? _____

6. DO YOU HAVE ANY JOINT OR VALVE REPLACEMENTS? _____ PLEASE DESCRIBE _____

_____

7. HAVE YOU HAD ANY MAJOR SURGERY? _____ PLEASE DESCRIBE _____

_____

8. HAVE YOU HAD ANY BLEEDING OR HEALING PROBLEMS? _____

9. ARE YOU ALLERGIC TO ANY MEDICATIONS? _____ PLEASE LIST _____

_____

10. HAVE YOU EVER HAD PENICILLIN? _____ HAVE YOU HAD ANY REACTION TO PENICILLIN? _____

11. ARE YOU PREGNANT / NURSING? _____

12. DO YOU HAVE ANY OTHER ILLNESS / CONDITION NOT LISTED ABOVE THAT WE SHOULD KNOW ABOUT? PLEASE EXPLAIN

_____

13. HAVE YOU HAD ANY PROBLEMS ASSOCIATED WITH PREVIOUS DENTAL TREATMENT? _____

PLEASE EXPLAIN _____

14. NAME OF MEDICAL DOCTOR _____

15. SIGNATURE _____

WESTCHESTER PUTNAM ENDODONTIC ASSOCIATES, P.C.
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 changes are permitted by applicable law. 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 use and disclose health information about you for treatment and payment for example.

Treatment: We may use or 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 payment for services we provide to you.

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 describe 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 disclosure permitted by your authorization while it was in affect. 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 Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

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 or, your general condition. 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.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or partner under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

WESTCHESTER PUTNAM ENDODONTIC ASSOCIATES, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

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

_____

(Signature) (Date)

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health Services.

Contact Officer: Barry Rothenhaus, D.M.D.

Telephone: 914-241-1177 Fax: 914-241-9008

Address: 101 South Bedford Road, Suite 410, Mt. Kisco, NY 10549

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 the acknowledgement.
- ❑ Other (please specify)

_____

_____

_____

This form is educational only, does not constitute legal advice, and covers only federal, not state law. (August 14, 2002).

WESTCHESTER PUTNAM ENDODONTIC ASSOCIATES, P.C.

ENDODONTIC CONSENT AND TREATMENT FORM

We would like to welcome you to our office. It is important that you be informed about various procedures involved in endodontic care. Please take a moment to carefully read this form. If you have any questions, the doctor will be happy to answer them prior to treatment.

ENDODONTIC THERAPY (root canal) is accomplished to try and save a tooth which would otherwise require extraction. The treatment may involve standard root canal therapy, or endodontic surgery. There are alternatives to root canal therapy. These include waiting for more definite symptoms to develop, tooth extraction, or no treatment at all. The risks involved in these choices may include pain, infection and loss of teeth and spread of infection.

TREATMENT COMPLICATIONS may be discovered which alter the original treatment plan, or may require endodontic surgery. These complications may include blocked canals, curved roots, fractures or perforations of the teeth, and instrument separation. Damage to temporary or permanent crowns, bridges or other restorations may occur, necessitating replacement at the patient's expense.

SURGICAL TREATMENT may be necessary in some cases. Complications from surgery may involve swelling, sensitivity, bleeding, infection, numbness and tingling of the lip, tongue, chin, cheeks and teeth, which usually disappears, but may be permanent, bruising of the skin, opening into the sinus or nose, recession of gingiva, or damage to adjacent teeth. Apical surgery, if necessary, will require a tissue specimen to be sent to a Pathology Lab for biopsy. For this procedure, the patient will be billed directly from the Lab.

ROOT CANAL THERAPY has a high degree of success. However, no reputable practitioner can guarantee this success. Occasionally a tooth which has had root canal therapy may require retreatment, surgery or even extraction.

CONSENT: I, the undersigned, being the patient (parent or guardian of minor), consent to the performing of endodontic procedures deemed advisable in the opinion of the doctor. I also understand that following completion of treatment in this office, I shall return to my referring and/or regular dentist for restoration of the tooth involved. I have read the above statements and understand that the doctor will answer any questions prior to initiating treatment.

_____ _____

name of patient (please print) signature (patient or parent)

_____ _____

witnessed by date