

GENERAL PATIENT INFORMATION

Patient Registration

Patient Information

Full Name: _____

Date of Birth: _____

Marital Status: Single Married Separated Divorced Widowed

Sex: Male Female

SSN/ID: _____

Email Address: _____

Home Phone Number: _____

Cell Phone Number: _____

Drivers License

State: _____

Number: _____

Home Address:

Address: _____

City, State and ZIP: _____

Billing Address:

Address: _____

City, State and ZIP: _____

Work Information

Employer: _____

Occupation: _____

Work Phone Number: _____

Method of Contact: Phone Email Text Message Any of the previous ones

Emergency Contact:

Full Name: _____

Phone Number: _____

Relation: _____

How did you hear about our office?

Who may we thank for referring you? _____

GENERAL PATIENT INFORMATION

Financial Information

Patient's Payment Details – Guarantor (Person responsible for paying the bill)

Guarantor Name: _____

SSN/ID: _____

Relation to Patient: _____

Patient's Student Status

Student Status: _____

College: _____

College Address: _____

Primary Dental Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: _____

Date of Birth: _____

SSN/ID: _____

Employer: _____

Policy Number: _____

Group Number: _____

Coverage Type: Individual Family Prepaid / Capitation

Insurance Company: _____

Company Phone Number: _____

Company City, State, ZIP: _____

Secondary Dental Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: _____

Date of Birth: _____

SSN/ID: _____

Employer: _____

Policy Number: _____

Group Number: _____

Coverage Type: Individual Family Prepaid / Capitation

Insurance Company: _____

Company Phone Number: _____

Company City, State, ZIP: _____

Pharmacy Information

Name: _____

Address: _____

Pharmacy Phone Number: _____

I authorize the dentist to release any information, including diagnosis, treatment plans/records and radiographs to third party payers and/or health practitioners. I authorize and request that my insurance company (if applicable) pay directly to the dental group or dentist benefits that are, otherwise, payable to me. I understand that my dental insurance may pay less than the actual bill for service or may not cover certain treatment.

I hereby certify that the foregoing information is accurate and complete and that in consideration of treatment and services rendered to me or my dependents by this dental office, I accept responsibility and agree to be obligated to pay the office in accordance with its payment and credit terms and policies.

Signature: _____

PATIENT MEDICAL HISTORY

Patient's Medical History

Physician Information

Physician's Full Name: _____

Address: _____

City, State and ZIP: _____

Are you currently under a physician's Care? Yes No

If Yes, for what?

Are you taking any medication, drugs or pills? Yes No

If so, please list the names and dosages of each:

Have you been hospitalized in the last two years? Yes No

If Yes, for what?

Do you Smoke? Yes No

How Much? _____

Women Only

Are you pregnant? Yes No

What is your due date? _____

Are you nursing? Yes No

Are you taking birth control pills? Yes No

Are you on Hormone Therapy? Yes No

Patient's Current or Previous Conditions

Select any of the following if you presently have or have had the condition in the past:

Medical Alerts

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Allergic to Penicillin | <input type="checkbox"/> Allergic to Codeine | <input type="checkbox"/> Pre-Medication required | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Allergic to Tetracycline | <input type="checkbox"/> Allergic to 'Novocaine' | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Allergic to Aspirin | <input type="checkbox"/> Allergic to Latex Rubber | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Prior Hepatitis |
| <input type="checkbox"/> Allergic to Sulfa | <input type="checkbox"/> Allergic to Metals | <input type="checkbox"/> Allergic to Food | <input type="checkbox"/> Allergic to Dental Anesthetics |
| <input type="checkbox"/> Other | | | |

Medical Conditions

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Excessive Bleeding when Cut | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Gastrointestinal Upset | <input type="checkbox"/> Artificial Joint Replacement |
| <input type="checkbox"/> Congenital Heart Problem | <input type="checkbox"/> Diabetes: Type _____ | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Extreme Nervousness |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting or Dizziness |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Cold Sores/Fever Blisters |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hepatitis A, B or C | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Deep Vein Clot | <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> HPV (Human Papillomavirus) |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> TIA (Mini Stroke) | <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Cortisone Treatment |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> AIDS/HIV Tcell Count | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pace Maker | |
| <input type="checkbox"/> MVP with/without regurgitation | <input type="checkbox"/> Tumor or growth on head or neck | <input type="checkbox"/> Radiation Treatment: When? _____ | |

PATIENT DENTAL HISTORY

Patient's Dental History

What is your primary reason for seeking dental care? _____

Previous Dentist Information

Dentist's Full Name: _____

City, State and ZIP: _____

Month and Year of Last Visit: _____

What was done at your last visit? _____

Date of Last full mouth x-rays: _____

Reason for leaving previous dentist: _____

How often do you visit the dentist? Annual Check Up Twice a Year Check Up Only when I have a problem Other

Please choose the appropriate answer

Are you nervous about receiving dental treatment? Yes No Are you missing teeth that have not been replaced? Yes No

Do you gag easily? Yes No Have you had excessive bleeding after an extraction? Yes No

Have you had previous problems with dental care? Yes No Do you take any Bisphosphonate medication such as

If so, please explain? Yes No Fosamax, Boniva, Actonel, Aredia or Zometa? Yes No

Have you had mouth sores that take long to heal? Yes No

Do you have any dental implants? Yes No

Are your teeth sensitive to hot, cold, pressure or sweets? Yes No Do you wear dentures (partials or full)? Yes No

Do you have problems with teeth/fillings breaking? Yes No Do you have any crowns (caps) or bridges? Yes No

Do you have blisters on your lips or mouth? Yes No Do you chew tobacco? Yes No

Do you feel pain when brushing? Yes No Do you smoke cigarettes/pipe/cigars? Yes No

Do you have crowded teeth? Yes No Do you have a dry mouth? Yes No

Have you ever had sores/growths in your mouth? Yes No Do you bite your fingernails? Yes No

Do you have a burning sensation on your tongue? Yes No Does your jaw ever hurt? Yes No

Do you chew on one side of your mouth? Yes No Do you experience jaw tiredness? Yes No

Do you bite your lip/cheek? Yes No Does your jaw ever get "stuck"? Yes No

Are you a mouth breather? Yes No Do you have a Temporomandibular (TMJ) jaw disorder? Yes No

Are you aware of an uncomfortable bite? Yes No Have you ever received orthodontic treatment? Yes No

Are your teeth loose or shifting? Yes No Do you have any crowns (caps) or bridges? Yes No

Do your gums bleed? Yes No Are you unhappy with the appearance of your teeth? Yes No

Do your gums feel swollen or tender? Yes No Would you like your smile to look better? Yes No

Does food catch between your teeth? Yes No Would you like whiter teeth? Yes No

Do you have bad breath? Yes No Would you like straighter teeth? Yes No

Have you had periodontal (gum) treatments? Yes No Do you regularly use dental floss? Yes No

Do you get sores in or around your mouth? Yes No Do you brush at least once daily? Yes No

Do you have regular headaches, earaches or neck pains? Yes No Have you worn braces on your teeth? Yes No

Do you grind or clench your teeth? Yes No Is there anything else that you would like us to know? Yes No

Do you hear a "clicking" sound when you open/close your mouth? Yes No

Oral Cancer Questionnaire

Do you have or have you ever had any of the following? Please Check all that apply:

Persistent Ear Pain Difficulty Swallowing Change in voice Persistent Hoarseness HPV (Human Papillomavirus)

I authorize the use of my radiographs [x-rays] and/or photographs for educational and promotional use in seminars, publications and the dental office web site.

I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in completion of this form.

Signature: _____



Financial Policy

Thank you for choosing Modern Dentistry of Long Island as your Dental Health Care Provider.

Our primary mission is to deliver the best and most comprehensive Dental Care in a comfortable and caring environment. Please understand that payment of your bills is considered a part of your treatment. You are responsible to know your Dental Insurance guidelines and limitations as well as the need to inform us of any changes if they occur. The following is a statement of our Financial Policy, which we require you to read and sign prior to the initiation of any treatment.

Patients Without Insurance: Patients with discounted dental plans and patients without insurance are expected to make full payments at the time of service. You can choose from Cash, Checks, Visa/MasterCard and Discover. In the event the balance cannot be paid in full, a credit card must be kept on file and a payment arrangement must be established. We offer extended payment plans with prior credit approval. In addition we offer a 5% Pre-payment courtesy accounting adjustment to patients who pay for their treatment with cash, money order or certified check prior to completion of care for treatment plans of \$1,000 or more.

Regarding Insurance: Patients are required to pay the deductible and copay at the time of your visit as specified by your dental benefits unless we participate with your plan in full. It is your responsibility to inform us of any changes to your account pertaining to your insurance coverage. Any balances occurring due to changes with your insurance that we are not made aware of will be your responsibility. Pre-authorizations are not a guarantee of payment and in the event treatment is completed and denied by your insurance company the balance is your responsibility. I further understand that my insurance can only be estimated and that rarely an insurance company will pay all costs. I know that I am responsible for all costs not paid by my insurance company. In the event that we do not accept assignment of benefits we require that you be pre-approved on our extended payment plan or provide a credit card with authorization to bill that account for the balance.

Regarding Treatment:

At Modern Dentistry of Long Island, we believe that Composite (Tooth Color) fillings are a far superior restoration when compared to Amalgam (Mercury Silver Color) fillings. Although we do not believe that amalgam fillings pose a threat to the health or well-being of any patients, composite fillings are the filling material of choice in this practice. There are several reasons for that decision, including but not limited to, the enhanced cosmetic tooth appearance and the ability to conserve healthy tooth structure. Therefore, as a standard of care, Composite fillings will be placed unless Amalgam fillings are specifically requested by the patient prior to the initiation of treatment. As a standard of care we also provide Flouride treatments once a year to adults and twice a year for children at a minimum, unless caries risks indicate otherwise. It is the patient's (or patient's guardian's) responsibility to know and understand the limitations of their specific Dental Plan as some do not cover or allow for Composite fillings and Flouride treatments. If you have any questions please ask.

Minor Patients:

The adult accompanying a minor and the parents (or guardian of the minor) is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, Discover or payment by cash or check at the time of service has been verified.

Missed Appointments:

Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit starting at \$75. Please help us serve you better by keeping scheduled appointments.

Returned Checks and Late Fees:

I have been advised that if my account exceeds 90 days past due there will be an interest charge of 12% for a year from the time of service. Furthermore, in the event that my account is transferred to a collection agency an additional 33% penalty will be added to the balance. If a check is returned there will be \$40 bank fee added to your account and future payments will only be accepted if made by certified check, money order, cash or credit card.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read, understand, and agree to the terms on this Financial Policy.

X: _____
Please Print Patient Name

X: _____
Please Print Responsible Party Name

X: _____ Date: _____



714 main street . port jefferson . ny . 11777
(p) 631.473.0582 (f) 631.473.3525
moderndentistryli.com

Insurance Payment Authorization/Signature On File Authorization

Primary Medical Insurance Co. _____

Secondary Medical Insurance Co. _____

Primary Dental Insurance Co. _____

Secondary Dental Insurance Co. _____

I hereby authorize my (insurance company[s]) to pay directly to the below named office, benefits due by me out of indemnity under the terms of my policy issued by your company. I authorize the use of this form for medical and dental insurance submissions, and release of information with payment made directly to Modern Dentistry of Long Island. I permit a copy of this to be used in place of the original. Payment directed, in whole or part, shall be considered the same as if paid, by your company, directly to me (the insured).

Insured Name: _____

Social Security #: _____

Primary Medical Ins. Policy #: _____ **Group #:** _____

Primary Dental Ins. Policy #: _____ **Group #:** _____

Insurance Billing Policies

1. I understand that I am ultimately responsible for payment in full for services provided by Modern Dentistry of Long Island. Use of insurance within the guidelines of my medical or dental insurance policy is permitted.
2. In the event of default, declines, or rejection of claims by me or my insurance carrier, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this debt.
3. The staff of Modern Dentistry of Long Island will assist in processing your insurance claims. Your eventual reimbursement or coverage will be determined by your insurance carrier. Any deductibles or co-payments are due at the time of service or immediately upon notification of this office.

I agree to the above billing policies and authorization for billing.

Patient Name: _____

Patient Signature: _____ Date: _____

Parent or Responsible Party Signature: _____

Relationship to Patient: _____ Date: _____

NOTICE OF PRIVACY PRACTICES FOR THE OFFICES OF:

Modern Dentistry of Long Island

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.

If you have any questions about this notice, please contact

Modern Dentistry of Long Island

Of our office at

714 Main St
Port Jefferson, NY 11777

frontdesk@moderndentistryli.com
631 473 0582

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment

We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders

We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services

We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law

We will disclose health information about you when required to do so by federal, state or local law.

Research

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation

If you are an organ donor, we may release health information to organizations that handle organ procurement, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Special Situations

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required by Law

We will disclose health information about you when required to do so by federal, state or local law.

Research

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation

If you are an organ donor, we may release health information to organizations that handle organ procurement, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security & Intelligence

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

Public Health Risks

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order.

Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors

We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Proof of Immunization

We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agreed to the disclosure on behalf of yourself or your dependent.

Specialized Government Functions

We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

Information Not Personally Identifiable

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Change of Ownership

In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Breach Notification

In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances, our business associate may provide the notification. We may also provide notification by other methods as appropriate.

Other Uses and Disclosures Of Health Information

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you that complies with the law governing HIV or substance abuse records.

Your Rights Regarding Health Information About You

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to:

Modern Dentistry of Long Island

Of our office at

714 Main St
Port Jefferson, NY 11777

frontdesk@moderndentistryli.com
631 473 0582

in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend or Supplement

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- Is not part of the health information that we keep.
- You would not be permitted to inspect and copy.
- Is accurate and complete.

It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request

We may not (and are not required to) agree to your restrictions with one exception: If you pay in full (out of pocket) for a service you receive from us, and you request that we do not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

If we do agree we will comply with your request unless the information is needed to provide you emergency treatment.

We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact:

Modern Dentistry of Long Island

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to:

Modern Dentistry of Long Island

Of our office at

714 Main St
Port Jefferson, NY 11777

frontdesk@moderndentistryli.com
631 473 0582

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right-hand corner. You are entitled to a copy of the notice currently in effect.

To request restrictions, you may complete and submit a Request For Restricting Uses and Disclosures and Confidential Communications Form Information to:

Modern Dentistry of Long Island

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the Requests For Restricting Uses and Disclosures and Confidential Communications to:

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact:

Modern Dentistry of Long Island

You will not be penalized for filing a complaint.

Signature
