Adirondack
PERIODONTICS, PLLC
Exclusively Periodontics & Procedures in Implant Dentistry

Dear

Enclosed are your new patient forms. **Please fill them out and mail them back to our office prior to your appointment, along with a copy of your insurance cards, if you have insurance**. If completed new patient forms are not received, we may need to reschedule your appointment. A return self-addressed envelope is enclosed for your convenience.

Your appointment is scheduled on:

Our office is located at 4161 Route 22, Exit 36 off Interstate 87, Plattsburgh, NY.

If you have any questions or concerns prior to your appointment, please feel free to call.

Thank you and we look forward to meeting you.

Adirondack Periodontics, PLLC
4161 Route 22 Plattsburgh, NY 12901
Exit 36 off Interstate 87
Office: 518-563-0040
Fax: 518-562-0632
Adkperiodontics@gmail.com

Welcome to our Practice

PATIENT INFORMATION:

Today's Date _____

❑Mr. ❑Mrs. ❑Ms. ❑Dr. First Name _____ M.I. _____ Last Name _____

Sex: ❑ Male ❑ Female Birth Date _____ Age_____ Soc. Sec. # _____ Email: _____

Street _____ Apt._____ City _____ State _____ Zip _____

Home Tel.(_____) _____ Cell(_____) _____ Have you ever been a patient of our practice? ❑Yes ❑No

Referred By _____ _____ Has a family member ever been a patient of our practice? ❑Yes ❑No
(FIRST NAME) (LAST NAME)

Dentist _____ _____ Orthodontist _____ _____ Medical Dr. _____
(FIRST NAME) (LAST NAME) (FIRST NAME) (LAST NAME) (FIRST NAME) (LAST NAME)

Driver's Lic.# _____ Nearest relative not living with youu _____ _____ Tel.(_____) _____
(FIRST NAME) (LAST NAME)

Employer _____ Bus. Tel. (_____) _____ Personal Payment Type ❑Cash ❑Check ❑Credit Card

In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOU ACCOUNT:

❑Self (If self, skip this section). ❑Spouse ❑Father ❑Mother ❑Other _____

Name _____ _____ S.S.# _____ Birth Date _____ Age _____
(FIRST NAME) (LAST NAME)

Tel.(_____) _____ Cell (_____) _____ Email _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Driver's Lic.# _____ Employer _____ Bus. Tel(_____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION: (IF DIFFERENT FROM ABOVE)

Name _____ _____ Relation _____ S.S.# _____ Birth Date _____
(FIRST NAME) (LAST NAME)

Street _____ Apt. _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel. (_____) _____

INSURANCE INFORMATION

Student..... ❑Full Tiume ❑Part Time ❑Not School Name and Address _____ _____
(SCHOOL NAME) (ADDRESS)

Marital Status.... ❑Married ❑Divorced ❑Widow ❑Single ❑Legally Separated _____ _____

Employed..... ❑Full Time ❑Part Time ❑Retired ❑Not Do you belong to a PPO or HMO ❑Yes ❑No

PRIMARY DENTAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ _____ _____ _____
(ADDRESS) (CITY) (STATE) (ZIP)

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____ I.D.# _____

Address _____ _____ _____ _____
(ADDRESS) (CITY) (STATE) (ZIP)

Tel. (_____) _____ Group Name _____

Group# _____ Insured Party _____
(FIRST NAME) (LAST NAME)

Relation _____ Birth Date _____ Sex ❑M ❑F

S.S.# _____ Tel. (_____) _____

Address _____ _____ _____ _____
(ADDRESS) (CITY) (STATE) (ZIP)

PRIMARY MEDICAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ _____ _____ _____
(ADDRESS) (CITY) (STATE) (ZIP)

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____ I.D.# _____

Address _____ _____ _____ _____
(ADDRESS) (CITY) (STATE) (ZIP)

Tel. (_____) _____ Group Name _____

Group# _____ Insured Party _____
(FIRST NAME) (LAST NAME)

Relation _____ Birth Date _____ Sex ❑M ❑F

S.S.# _____ Tel. (_____) _____

Address _____ _____ _____ _____
(ADDRESS) (CITY) (STATE) (ZIP)

SECONDARY DENTAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ _____ _____ _____
(ADDRESS) (CITY) (STATE) (ZIP)

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____ I.D.# _____

Address _____ _____ _____ _____
(ADDRESS) (CITY) (STATE) (ZIP)

Tel. (_____) _____ Group Name _____

Group# _____ Insured Party _____
(FIRST NAME) (LAST NAME)

Relation _____ Birth Date _____ Sex ❑M ❑F

S.S.# _____ Tel. (_____) _____

Address _____ _____ _____ _____
(ADDRESS) (CITY) (STATE) (ZIP)

SECONDARY MEDICAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ _____ _____ _____
(ADDRESS) (CITY) (STATE) (ZIP)

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____ I.D.# _____

Address _____ _____ _____ _____
(ADDRESS) (CITY) (STATE) (ZIP)

Tel. (_____) _____ Group Name _____

Group# _____ Insured Party _____
(FIRST NAME) (LAST NAME)

Relation _____ Birth Date _____ Sex ❑M ❑F

S.S.# _____ Tel. (_____) _____

Address _____ _____ _____ _____
(ADDRESS) (CITY) (STATE) (ZIP)

HEALTH HISTORY:

To our patients: *Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

Reason for today's visit? _____

		Yes	No
1.	Height _____ Weight _____ Are you in good health.....	❑	❑
2.	Have there been any changes in your general health in the past year?.....	❑	❑
3.	Are you under the care of a physician .....Date of last visit _____ If so, for what are you being treated?_____	❑	❑
4.	Have you had an illness, operation or been hospitalized in the past five years?..... If so, describe_____	❑	❑
5.	Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?..... If so, describe where_____	❑	❑
6.	Do you have a prosthetic joint/implant?..... If so, describe where _____	❑	❑
7.	Have you had a heart valve replacement or vascular graft?.....	❑	❑
8.	**Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?** . If yes, Reason?_____	❑	❑

HAVE YOU HAD OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
10. Rheumatic fever:			
11. Damaged heart valves/ mitral valve prolapse?			
12. Heart murmur?			
13. High blood pressure?			
14. Low Blood Pressure?			
15. Chest pain / angina?			
16. Heart attack(s)?			
17. Irregular heart beat?			
18. Cardiac pacemaker?			
19. Heart surgery?			
20. Pneumonia, bronchitis, chronic cough?			
21. Asthma?			
22. Hay fever / sinus problems?			
23. Snoring / sleep apnea			
24. Difficulty breathing / other lung trouble?			
25. Tuberculosis?			
26. Emphysema?			
27. Do you smoke? if so, number of packs a day?			
28. Do you use chewing tobacco?			
29. Blood transfusion?			
30. Blood disorder such as anemia?			
31. Bruise easily?			
32. Bleeding tendency / abnormal bleed?			
33. Hepatitis, jaundice, or liver disease?			
34. Infectious mononucleosis?			
35. Gallbladder trouble?			
35. Fainting spells?			
37. Convulsions / epilepsy?			

HAVE YOU HAD OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
38. Stroke?			
39. Thyroid trouble?			
40. Diabetes?			
41. Low blood sugar?			
42. Kidney trouble?			
43. High cholesterol?			
44. Are you on dialysis?			
45. Swollen ankles / arthritis / joint disease?			
46. Osteoporosis / osteopenia?			
47. Osteonecrosis?			
48. Stomach ulcers / acid reflux?			
49. Contagious diseases?			
50. Sexually transmitted diseases?			
51. Problems with immune system? Possibly from medication / surgery, etc.			
52. Delay in healing			
53. A tumor or growth			
54. Cancer / radiation therapy / chemotherapy?			
55. Chronic fatigue? night sweats?			
56. Are you on a diet?			
57. A history of alcohol abuse?			
58. A history of drug abuse?			
59. Contact lenses?			
60. Eye disease / glaucoma?			
61. Mental health problems / anxiety / depression?			
62. A removable dental appliance?			
63. Pain or clicking of jaws when eating?			

WOMEN ONLY: *(QUESTIONS 64-67)*

		Yes	No
64.	Is there a possibility of pregnancy.....	❑	❑
65.	Expected delivery date?_____		
66.	Are you nursing	❑	❑
67.	Are you taking birth control pills.....	❑	❑

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*

ARE YOU NOW TAKING:	YES	NO	NOTES
72. Any kind of medication, drug, pills?			
73. Blood thinners (Coumadin, Pahlavi, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)?			
74. Have you ever taken diet pills?			
75. Any natural product herbal supplement or homeopathic remedy?			
76. Are you taking, or have you ever taken, bone density meds, or bisphosphonates such as Fosamax, Boniva, Actonel IV-Zometa, Aredia, or Reclast in the past 12 years?			
77. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:			
78. Please list any medications you are currently taking: | Medication | Dosage | Frequency |			

ARE YOU ALLERGIC TO OR HAD A REACTION TO:	YES	NO	NOTES
79. Local anesthetic (numbing meds.)?			
80. Penicillin?			
81. Other antibiotics? If so, please specify			
82. Sulfa drugs?			
83. Sodium pentothal? Valium? other tranquilizers			
84. Aspirin			
85. Amoxicillin?			
86. Codeine or other narcotics?			
87. Other medications?			
88 Latex?			
89. Soy?			
90. Eggs / yolk?			
91. Sulfites?			
92. Do you have any known allergies?			
93. Please list any allergies other than drug allergies:			

Is there a family history of:

❑ Cancer ❑ Diabetes ❑ Heart Disease ❑ Anesthesia problems

Is this visit related to an accident: ❑ Yes ❑ No

If yes, what type of accident? ❑ Automobile ❑ Work related ❑ Other

Date of Injury _____

Insurance company handling the claim _____

Claim number _____

Name of attorney / adjustor _____

Telephone number (_____) _____

Is there any condition concerning your health that the Doctor should be told about? ❑ Yes ❑ No - If Yes, describe

_____

Do you wish to speak to the Dr. privately about anything? ❑ Yes ❑ No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ X _____ X _____

Signature of patient (Parent of Guardian if Minor) Reviewed by Date

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangement can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you. If you have any dental and/or medical insurance we will be glade to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge.

X _____ X _____

Signature of patient (Parent of Guardian if Minor) Date

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ X _____

Signature of patient (Parent of Guardian if Minor) Date

AUTHORIZATION

I authorize my surgeon and his/her designated staff, to perform an oral and maxillofacial examination, for the prupose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers.

X _____ X _____

Signature of patient (Parent of Guardian if Minor) Date

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.

X _____ X _____

Signature of patient (Parent of Guardian if Minor) Date

Adirondack
PERIODONTICS, PLLC
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WELCOME TO OUR OFFICE:

APPOINTMENTS: Our office will provide you with the finest and most up-to-date periodontal care. Continuity of care is critical to the success of periodontal treatment. We understand that you may occasionally need to change your appointment. We ask that you give us 2-business days' notice for all appointment changes. Otherwise a fee may be charged.

PAYMENT: Payment for treatment is expected at the time services are rendered. MasterCard, Visa, Discover, personal checks and cash are accepted. We are pleased to provide another healthcare financing option as well, CARE CREDIT. It is accepted by our office and other dental and medical offices in the area. Please inform us if you wish to find out more about this service. We will do everything we can to help you receive the care you need. Communication with us is essential.

INSURANCE: We are happy to submit your dental insurance claims but ask for payment at the time of service. We need our patient information form filled out completely or a completed insurance form provided by your employer. If you prefer to submit your own insurance, we will provide you with a statement of services at the time of your visit. You should receive reimbursement in 30 days. The amount reimbursed varies widely depending upon the policy level chosen and purchased by your employer.

PRE-ESTIMATE: Insurance companies sometimes require a pre-estimate of benefits. The clinical information required can be obtained after a complete examination and treatment discussion (2 visits). We will submit the pre-estimate for you and provide additional information to the insurer as needed. Your insurance company should estimate coverage for services in approximately 4-6 weeks.

AVAILABLE FOR YOUR CARE:

Comprehensive non-surgical, surgical, regenerative and reconstructive periodontics
Placement of Dental Implants
Halitosis (Bad Breath) Analysis and Treatment Program
Snoring Elimination Appliance
Migraine Headache Treatment Appliance
Laser Periodontal Treatment

Adirondack Periodontics, PLLC
4161 State Route 22, Plattsburgh, NY 12901
Office: 518-563-0040
Fax: 518-562-0632
adkperiodontics@gmail.com

ADIRONDACK PERIODONTICS, PLLC

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

Adirondack Periodontics is required by the 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 09/23/13 and will remain in effect until we replace it. We reserve the right to change our policy 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 significant changes 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

Adirondack Periodontics will use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician, dentist, 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.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

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 disclose 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 disclosures 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 Patients 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, your general condition, or death. 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 determination using 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.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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

Other: We may use or disclose your health information (i.e. that you are a patient of this office) when we leave voicemail messages, send postcards, letters, or email to confirm appointments, check on how you are doing, post treatment calls, x-ray diagnosis, and lab results.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to address at the end of this Notice.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree with these additional restrictions, but if we do, we will abide by our agreement (except in emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice by electronic mail (e-mail), adirondacksperio@aol.com you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with us or with the U.S. Department of Health and Human Services upon request. 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 and Human Services.

Contact Officer: Dr. Gordon H. Davis
Telephone: (518) 563-0040 Fax: (518) 562-0632
E-mail: adkperiodontics@gmail.com

Address: Adirondack Periodontics, PLLC
Plattsburgh, New York 12901

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RE: _____
PLEASE PRINT FIRST AND LAST NAME

Date of Last Physical _____

PHYSICIAN's name_____

Address _____
Please print physician's address and phone number

The above mentioned patient is undergoing periodontal therapy at our office, a portion of which may include periodontal surgery and the use of epinephrine containing anesthetics.

We would appreciate your advice regarding any allergies, medications being taken, need for premedication, and any significant medical aspects of this patient's history.

Please fax your response to (518) 562-0632 or mail to 4161 Route 22, Plattsburgh, New York 12901. Thank you very much for your assistance.

Sincerely,

Gordon H. Davis, DMD, DMSc

I authorize release of any medical information to Dr. Davis.

_____ _____/_____/_____
(PATIENT SIGNATURE) DATE

Date of Birth: _____/_____/_____

Adirondack Periodontics, PLLC
4161 Route 22, Plattsburgh, NY 12901
Office: 518-563-0040
Fax: 518-562-0632
Dr. Davis: 518-562-3176 home
adkperiodontics@gmail.com