Kaufman Dental Associates

1035 South State Road 7, Wellinton, Fl 33414
561-333-2545 e-mail: info@kaufmandental.com
www.kaufmandental.com

Welcome to our office! We appreciate the confidence and trust that you have placed in us and look forward to meeting you personally and professionally.

Our philosophy of care governs everything we do for you. It consists of the following key elements:

- ✓ We are truly caring about our patients and want you to feel very comfortable with our entire staff.
- ✓ We recognize that each patient is an individual and our goal is to help you retain your teeth in comfort, function and esthetics for a lifetime.
- ✓ We work with only one patient at a time, and do not double book. The time that you reserve with us is yours and yours alone.
- ✓ We strive to be thorough in everything we do, taking the time to be the best we can be.
- ✓ We are esthetics oriented, helping you look your best, while maintaining optimum comfort, function and health.

At your first visit, we will take the time to get to know you (and you, us) and discuss your dental needs and desires. We will perform a comprehensive dental evaluation and gather information to make a customized plan for you.

Enclosed you will find our new patient information forms. Please fill them out and bring it with you to your first appointment along with a list of any medications that you take.

We look forward to meeting you.

Sincerely,

Marianna Kaufman DMD and Staff

P.S. Please visit our website at www.kaufmandental.com to learn more about us!

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PERMISSION TO USE INFORMATION

****You may refuse to sign this acknowledgement****

I, _____ have received a copy of this office's Notice of Privacy Practices. I give permission to use my health information to treat me as outlined in the Notice of Patient Privacy Practices.

_____
(Please Print Name)

_____
(Signature and 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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

Please note: Under current Florida Law we have the right to refuse to treat you if you do not sign this form. We will inform you if we choose that option.

KAUFMAN DENTAL ASSOCIATES

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell)_____ (Work): _____Ext: _____

Email address:_____Preferred method of contact: □ Email □ Phone call/ Voicemail

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes – do you wear an Insulin Pump? Y N
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis? **A B C**
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Latex Allergy
- ☐ High Cholesterol

Other:

- ☐ _____

Please list all medications you are taking: _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you happy with the color/appearance of your teeth? _____
- Have you ever been treated for Osteoporosis? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Article I. Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient ☐ Another Dental Office

☐ Website ☐ Google ☐ Yellow Pages Book ☐ Yellow Pages Online ☐ Yellowbook ☐ Direct Mail ☐ Insurance

Name of person or office referring you to our practice: _____

KAUFMAN DENTAL ASSOCIATES

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Section 1.01

Section 1.02 Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

KAUFMAN DENTAL ASSOCIATES

Dental History

Please describe your chief oral complaint: _____

_____

Are your teeth sensitive to:	Yes	No
Heat?	☐	☐
Cold?	☐	☐
Sweet?	☐	☐
Chewing?	☐	☐
Do you have any food traps?	☐	☐
Do your gums ever feel tender or swollen	☐	☐
Do your gums bleed when brushing?	☐	☐
Do you have any teeth that feel loose?	☐	☐
Have you ever been treated for periodontal disease or pyorrhea?	☐	☐
Do you use dental floss?	☐	☐
Have you had any previous injuries to your face or jaws?	☐	☐
Do you lose or break fillings?	☐	☐
Do you clench or grind your teeth	☐	☐
Do you seem to strike some teeth before others when closing?	☐	☐
Have you ever had your bite adjusted?	☐	☐
Do your jaws ever feel tired or Ache?	☐	☐
Can you chew comfortably On both sides of your mouth?	☐	☐
Have you ever experience Problems with Dental Anesthesia?	☐	☐

	Yes	No
Have you had a complete Examination, including full mouth x-rays, in the past 3 years?	☐	☐
Have you had your teeth cleaned Regularly?	☐	☐
When was your last cleaning?_____		
Do you have all or most of your natural teeth?	☐	☐
Would you like to keep your natural teeth?	☐	☐
If you had teeth removed, have they been replaced?	☐	☐
Do you like the appearance of your smile?	☐	☐

If you could improve your teeth or smile, what would you do?

_____

Do you consider yourself a nervous dental patient?	☐	☐
Would you like the doctor to speak to you about sedation?	☐	☐
Have you ever had an unpleasant dental experience?	☐	☐

When and where was your last dental visit?

_____

What was done at that visit?

_____

_____

Are you interested in financing?

_____

Financial Policy

We ask that you pay the cost of all treatment rendered as set by our office or by your insurance carrier on the day of that appointment. Please understand that financial arrangements are made directly with you. For the convenience of our patients, the following alternatives are listed as a guide for possible financial arrangements : ***(PLEASE INITIAL EACH ITEM AND SIGN AT THE BOTTOM).***

1. Payment due in full: For each appointment as services are rendered. We accept cash, personal checks, MasterCard, Visa, American Express, Discover as well as third party financing. A charge of $30 will be assessed on checks returned for any reason and for declined credit card transactions assigned for payment plans. Please note that all delinquent accounts will be pursued by a collection firm. Any accounts handled by a collection firm will accrue an additional 35% to 50% of the remaining account balance.

_____
Initials

2. Dental Insurance: Please realize that your insurance coverage is a relationship between you, the insured patient, and your insurance company. The type of plan chosen by you and/or your employer determines your insurance benefits. Marianna Kaufman, D.M.D, has no control over the terms of your contract, the method of reimbursement or the determination of your insurance benefits. As a courtesy to you, our office will process all claims to your insurance carrier. Please note that all insurance policies are different and it is your responsibility to know your plan provisions.

_____
Initials

3. Limitations Set By Insurance Companies: Please note that some insurance companies only cover certain dental procedures based on a time schedule (for instance, some insurance companies cover certain x-rays only once in a 12 month period, or topical fluoride treatment once in 12 month period). Do not misinterpret these limitations as your recommended treatment. **Dr. Marianna Kaufman will recommend the best necessary treatment for you regardless of your insurance limitations. It is your responsibility to be aware of these limitations and your financial responsibility.**

_____
Initials

4. Fillings: Our dental material of choice is a white (composite resin) filling. Please be advised that your insurance company may not pay for a resin filling at the same level as a silver (amalgam) filling. The co-payment is your responsibility.

_____
Initials

5. Nitrous Oxide (Laughing Gas): Nitrous oxide maybe used to reduce anxiety and apprehension. It not always covered by dental insurance.

_____
Initials

6. Appliances/Crowns: The entire cost of an appliance/ crown must be paid by the day that impressions are taken. This is necessary because our office must pay the laboratory fees when appliances/crowns are ordered, not when completed.

_____
Initials

7. Emergency Treatment: For first time patients presenting for emergency treatment, accounts must be paid in full at the time the service is rendered. Please remember, even if you have insurance coverage, you are responsible for payment of your account.

I have read and understand my obligation. _____
Initials

_____	_____	_____	_____
Signature of Patient or Guardian	Date	Relationship to Patient	Patient's name

Photo Release Form

I hereby grant Kaufman Dental Associates permission to use my likeness in a photograph in any and all of its publications, including website entries, without payment or any other consideration.

I understand and agree that these materials will become the property of Kaufman Dental Associates and will not be returned.

I hereby irrevocably authorize Kaufman Dental Associates to edit, alter, copy, exhibit, publish or distribute this photo for purposes of publicizing Kaufman Dental Associates's programs or for any other lawful purpose. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph.

I hereby hold harmless and release and forever discharge Kaufman Dental Associates from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I am 21 years of age and am competent to contract in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

_____ _____

(Signature) (Date)

_____ _____

(Printed Name) (Date)

If the person signing is under age 21, there must be consent by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of _____, named above, and do hereby give my consent without reservation to the foregoing on behalf of this person.

_____ _____

(Parent/Guardian Signature) (Date)

_____ _____

(Parent/Guardian Printed Name) (Date)

Kaufman Dental Associates

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 1 / 1 /2013, 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, payment, and healthcare operations. 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.

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 effect. 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, 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 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.

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 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 patient 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).

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 the address at the end of this Notice. If you request copies, we will charge you $_2.00_ for each page, $100.00_ per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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 to these additional restrictions, but if we do, we will abide by our agreement (except in an 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 on our Web site or by electronic mail (e-mail), 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 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. Marianna Kaufman

Telephone: 561-333-2545 Fax: _____

E-mail: kaufman@kaufmandental.com

Address: 1035 South State Road 7 Wellington, Fl 33414