Patient Information (Confidential)

Today's Date _____

Name _____ *Birthdate* ____ / ____ / _____ *Social Security #* _____ - _____ - _____

Address _____ *Apt #*_____ *City* _____ *State* _____ *Zip* _____

Home Phone _____ *Cell Phone* _____ *Work Phone*_____

Please Circle: *Minor* *Single* *Married* *Divorced* *Widowed* *Separated*

*Name of Person to Contact in Case of an Emergency*_____ *Phone #*_____

Financial Responsible Party *(or parent if minor)*

Name of Person Responsible for this Account _____ *Relationship to Patient* _____

Birthdate _____ / _____ / _____ *Social Security #* _____ - ___ - _____

Address _____ *Apt #* ____ *City* _____ *State* _____ *Zip* _____

*Home phone*_____ *Cell Phone*_____ *Work Phone* _____ *Ext.* _____

Dental Insurance Information

Name of Insured _____ *Relationship to Patient* _____

Birthdate _____ / _____ / _____ *Social Security #* _____ - ____ - _____

Name of Employer _____ *Work Phone* _____ *Ext.* _____

Address of Employer _____ *City* _____ *State* _____ *Zip* _____

Insurance Company _____ *Group #* _____ *Policy/ID #* _____

Insurance Co. Address _____ *City* _____ *State* _____ *Zip* _____

Medical Insurance Information

Name of Insured _____ *Relationship to Patient* _____

Birthdate _____ / _____ / _____ *Social Security #* _____ - ____ - _____

Name of Employer _____ *Work Phone* _____ *Ext.* _____

Address of Employer _____ *City* _____ *State* _____ *Zip* _____

Insurance Company _____ *Group #* _____ *Policy/ID #* _____

Insurance Co. Address _____ *City* _____ *State* _____ *Zip* _____

DO YOU HAVE ANY ADDITIONAL COVERAGE? ☐ ***Yes*** ☐ ***No*** ***IF YES, ASK FOR SECONDARY INSURANCE SHEET***

We are proud to welcome new patients to our office and would like to know who referred you? _____

Physician ____ *Dentist* ____ *Other* ____ *Name of Dentist*_____ *Name of Physician*_____

Name of Pharmacy _____ *Address* _____ *Phone Number* _____

Please complete the opposite side of the page. Thank you.

Patient Medical History

Height _____ Weight _____ Sex _____

Do you have or ever had any of the following ***(check only those that apply*** *– leave others blank):*

_____ *Heart Murmur*	_____ *Bleeding Disorder*	_____ *Arthritis*
_____ *Heart Disease*	_____ *Hepatitis, Liver Disease*	_____ *Stroke*
_____ *Heart Valve Problem*	_____ *Tuberculosis, Lung Disease*	_____ *Malignancy, (Cancer)*
_____ *Chest Pain*	_____ *Asthma*	_____ *Mental Illness*
_____ *Rheumatic Fever*	_____ *Hay Fever*	_____ *Nerve/Muscle Disease*
_____ *Epilepsy, Seizures*	_____ *Sinus Trouble*	_____ *TMJ Problems*
_____ *Diabetes*	_____ *Kidney Disease*	_____ *Facial Fractures*
_____ *High Blood Pressure*	_____ *Thyroid or other Gland Disease*	_____ *Venereal Disease*
_____ *Anemia*	_____ *Ulcers*	_____ *Stomach/Intestine Disease*
_____ *Sickle Cell Anemia*	_____*Strong Gag Reflex*	

Any other health problems? _____

Have you ever had surgery? _____ *When?* _____*For?* _____

Were you ever hospitalized for anything else? _____ *What?* _____ *When?* _____

Have you ever had general anesthetic? _____ *When?* _____ *Any problems?* _____

Have you ever had any pins, rods, plastic joints, shunts or valves permanently inserted into your body? _____

Are you pregnant? _____*Are you nursing?* _____ *Do you smoke, vape, chew?* _____*How often?* _____

Do you drink alcohol? _____ *How much?* _____ *How often?* _____

Do you have any pain or discomfort in your mouth currently? _____ *Do you feel nervous about having dental treatment?* _____

Medications

Are you taking any of the following medications for Osteoporosis or Bone metastases (Please Circle):

FOSAMAX ACTONEL BONIVA AREDIA ZOMETA RECLAST

Please list medications / vitamins / herbs you take daily:

_____

_____

_____

Allergies (Please Circle)

NKDA (No Known Drug Allergies) ASPIRIN PENICILLIN CODEINE SULFA IODINE/SHELLFISH LATEX

Any other allergies?

_____

Authorization and Release for Patient HIPPA Privacy and Financial Responsibilities.

I certify that I have read and understand the above information to the best of my knowledge and that all questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. We support your right to the privacy of your health information. We disclose your health information for treatment, payment or where applicable by federal and state law. I authorize Dr. Cecere to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during under his care to third party payers, health practitioners, family, friend or other person to the extent necessary to help with healthcare or with payment for your healthcare. I authorize and request my insurance company to pay directly to Dr. Cecere insurance benefits otherwise payable to me. I understand that my dental/medical insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that I may be charged a 1.5% per month if my balance goes beyond 30 days.

X_____ Date _____

Signature of patient (or parent if minor)

Doctors Signature _____ Date_____

William L. Cecere III, DDS, MD

ORAL AND MAXILLOFACIAL SURGERY

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.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

FOR OFFICE USE ONLY

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

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

_____

_____

_____

Email This Form | Print This Form | Save This Form

William L. Cecere III, DDS, MD

ORAL AND MAXILLOFACIAL SURGERY

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 **February 1, 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, 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.

T**o 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 $0.___ for each page, $ **10.00** per hour for staff time to locate and 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. William L. Cecere, III, DDS, MD**

Telephone: **(719) 823-1966** or **(719) 636-6280**

Address: **1050 Abbott Road, Buffalo NY 14220 or**
6161 Transit Road, Suite 3, E. Amherst, NY 14051