ClockTower Dental Associates, P.C.
Dr. Kelley and Rayhan
110 New Hyde Park Road
Franklin Square, NY 11010
www.clocktower-dental.com

We are complimented that you have selected us to provide dental care for you and your family.

Whom may we thank for referring you to our office? _____

Patient Information

Date _____ Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Ph. # (___)_____ Work Ph. # (___)_____ Soc. Sec. #_____-_____-_____ Drivers Lic. # _____

Birthdate ___/___/_____ Sex M F If patient is a minor, give parent's/guardian's name _____

Name of nearest relative not living with you _____ Relationship _____

If patient is a full-time student, fill in school name _____

Complete Address _____ Ph. # (___) _____

Emergency Contact _____ Ph. # (___) _____

Email address _____

Responsible Party Information

Name _____
Last First Middle Marital Status

Soc. Sec. #_____-_____-_____ Birthdate ___/___/___ Relationship to Patient _____

Residence _____
Street Apt# City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Ph.# (___) _____ Work Ph.# (___) _____ Fax# (___) _____

Previous Address (if less than 3 years) _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Spouse's Name _____ Relationship to Patient _____

Soc. Sec. # ___-___-_____ Birthdate _____/_____/_____ Work Ph.# _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec # _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ Ph. # (___) _____

Is policy connected with your union? Yes___ No ___ Name of Union _____ Local # _____

Do you have dual coverage? Yes___ No___ If yes: **Please complete the following secondary insurance information.**

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group # _____ Local # _____

Insurance Co. Address _____ Ph. # (___) _____

Insured's Employer _____ Ph. # (___) _____

Dental Information

Do your gums bleed when you brush? Yes___No___

Are your teeth sensitive to heat or cold? Yes___No___ Pressure? Yes___No___ Sweets? Yes___No___

Do you grind or clench your teeth? Yes___No___

Do you have any fear of dental work? Yes___No___

Date of last dental visit _____ What was done at the time? _____

Former Dentist Name _____

How would you describe your current dental problem? _____

Are you happy with your smile? Yes___No___

Would you like to discuss your smile? Yes___No___

Would you like to discuss whitening your teeth? Yes___No___

Please complete back page

Medical Information

1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been a patient in the hospital during the last two years ..... YES NO
3. Are you now taking any medication or drugs? ..... YES NO
   If yes, please list: _____
4. A. Have you taken any medication or drugs during the last two years? ..... YES NO
   B. Have you even taken appetite suppressants – fen-phen (fenluramine & phentemine) or dexfenfluramine or fenflurmeine? ..... YES NO
5. Have you been under the care of a medical doctor during the last two years or since taking any of the appetite suppressants named above? YES NO
   Physician's Name _____ Ph. # (____) _____
   Address _____
6. Are you sensitive or allergic to any medication or anesthetics? ..... YES NO
   If yes, please list: _____
7. Indicate which of the following you have had or have at the present. Circle "YES" or "NO" to each item YES NO

Heart Failure	YES	NO	Artificial Joints (hip, knee, etc)	YES	NO	Hepatitis A (infectious)	YES	NO
Heard Disease or Attack	YES	NO	Kidney Trouble	YES	NO	Hepatitis B (serum)	YES	NO
Angina Pectoris	YES	NO	Ulcers	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	A.I.D.S.	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	H.I.V. Positive	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Cold Sores/Fever Blisters	YES	NO
Arteriosclerosis	YES	NO	Cancer	YES	NO	Blood Transfusion	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Anemia	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Sickle Cell Disease	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Bruise Easily	YES	NO
Rheumatic Fever	YES	NO	Hay Fever	YES	NO	Liver Disease	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Yellow Jaundice	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Epilepsy or Seizures	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Fainting or Dizzy Spells	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Nervousness	YES	NO
Stroke	YES	NO	Developmentally Disabled	YES	NO	Tumors	YES	NO
Alergy to Latex	YES	NO	Allergy to Metal (jewelry, etc).	YES	NO			

8. Are you on a special diet? ..... YES NO
9. Do you have or have you had any disease, Condition, or problem not listed? ..... YES NO
   If yes, please list: _____

FOR WOMEN ONLY:
Are you pregnant? Yes ___ What month? _____ No ___ Are you nursing? Yes ___ Are you taking birth control pills? YES NO

CONSENT:

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.5% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that once the treatment has started, any money paid is non-refundable.
5. I understand that where appropriate, credit bureau reports may be obtained.
6. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
7. I authorize the use of my social security number to file my dental claim.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

FOR OFFICE USE: Reviewed by Dr. _____ Date _____

Notice of privacy practices for protected health information

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.

Uses and Disclosures

We may use or disclose your protected health information without your written consent, written authorization or oral agreement for the following purposes.

Treatment. Example: We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.

Payment. Example: We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

Health Care Operations. Example: We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

We may use or disclose your protected health information without your written consent, written authorization or oral agreement under the following circumstances:

If we provide services to you while you are an inmate.

If we provide services to you in an emergency treatment situation.

If we are required by law to provide services to you and we are unable to obtain your consent after attempting to do so.

If there are substantial barriers to communication and we determine, in the exercise of our professional judgement, that you intend for us to treat you.

If we need to notify, or assist in the notification of, a family member, personal representative or another person responsible for your care of your location, general condition or death.

If we are required by law to disclose your health information to a public health authority that is authorized to receive information for the purposes of preventing or controlling disease, injury or disability.

If we are required by law to disclose your health information to a public health or other government authority that is authorized to receive reports of child abuse or neglect.

If we are required to disclose your health information to the Food and Drug Administration.

If we are required to disclose your health information to your employer to evaluate whether you have a work-related injury or illness.

If we are required by law to disclose your health information to a government authority authorized to receive reports of abuse, neglect or domestic violence.

If we are required to disclose your health information to a health oversight agency or oversight activities required by law.

If we are required to disclose your health information in response to a court order or subpoena.

If we are required to disclose your health information to law enforcement official.

If we are required to disclose your health information to a coroner, medical examiner or funeral director.

For research purposes.

If we, in good faith, believe that the use of disclosure of your health information is necessary to prevent a serious threat to the health and safety of others.

If we are authorized by law to disclose your health information to comply with laws established to provide benefits for work-related injuries or illnesses.

WITH THE EXCEPTION OF THE ABOVE CIRCUMSTANCES, ANY USE OR DISCLOSURE OF YOUR HEALTH INFORMATION WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. YOUR WRITTEN AUTHORIZATION MAY BE REVOKED, IN WRITING AT ANY TIME EXCEPT TO THE EXTENT THAT WE HAVE PROVIDED SERVICES OR TAKEN ACTION IN RELIANCE ON YOUR AUTHORIZATION.

Your rights.

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to the requested restrictions. Your request to limit the use and / or disclosure of your health information must be made in writing to our privacy official.

Right to receive Confidential Communications. You have the right to receive confidential communications concerning your health information. Your request to receive confidential communications must be made in writing to our privacy official. We will accommodate all reasonable requests by you to receive your health information at a place other than your home address or by means other than regular mail.

Right to Inspect and / or copy. You have the right to inspect and / or copy certain health information for as long as that information remains in your record. Your request to inspect and / or copy your health information must be made in writing to our privacy official.

Right to Amend. You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our privacy official and you must provide a reason to support the requested amendment.

Right to Receive an Accounting. You have the right to receive an accounting of our disclosures of your health information made six (6) years prior to the date of request. We will provide you with the first (1st) accounting in any twelve- (12) month period at no charge. There will be a fee charged for any subsequent request. Your request to receive an accounting must be made in writing to our privacy official. The accounting will not include the following disclosures:

Disclosures made to carry out treatment, payment and health care operations (TPO);

Disclosures made to you;

Disclosures made in our facility directory;

Disclosures made to individuals involved with your care;

Disclosures made for national security or intelligence purposes;

Disclosures made to correctional institutions or law enforcement officials: and

Disclosures made prior to the compliance date of the HIPAA Privacy Rule.

Right to Receive Notice. You have the right to receive a paper copy of this notice, upon request.

Clock Tower Dental Associates P.C.
110 New Hyde Park Road
Franklin Square, N.Y.11010
(516) 352-1000

HEALTH CARE AUTHORIZATION FORM

Patient's Name _____

Patient's SS#_____ Date of Birth_____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES CLOCK TOWER DENTAL ASSOCIATES P.C. TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION INACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

I give permission to CLOCK TOWER DENTAL ASSOCIATES, P.C.

To use my address and clinical records to contact me with appointment reminders, missed appointment notification, leaving voice mail, birthday cards, holiday related cards information about treatment alternatives, marketing, using an in office referral board, testimonials, sending newsletters, open room adjusting /therapies/consultation or other health related information. I understand that this office will be using and disclosing PHI to contracted third party companies to assist in activities relating to treatment, payment, and healthcare operations.

If CLOCK TOWER DENTAL ASSOCIATES, P.C. contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

OTHER;

_____

_____

_____

_____

By signing this form you are giving CLOCK TOWER DENTAL ASSOCIATES, P.C. permission to use and disclose your protected health information in accordance with the directives listed above.

Sign_____ Date _____

The authorization will expire on the following date 01-01-2030

Notices of Privacy Practices
As required by the Privacy Regulations Created as a result of the Health Insurance And Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION,

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable Health information (IIHI). In conducting our business, we will create records regarding Your and the treatment and services we provide to you. Law to requires us Maintain the confidentially of health information that identifies you. We also are Required by law to provide you with this notice of our legal duties and the privacy Practices that we maintain in our practice concerning your IIHI. By federal and state Law, we must follow the terms of the notice of privacy practices that we have in effect The time.

We realize the these laws are complicated, but we must provide you with the following Important information;

How we may use and disclose your IIHI
Your privacy rights in your IIHI
Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or Retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your Records that we may create or maintain in the future. Our practice will post a copy of Our current Notice in our visible location at all times, and you may request a copy of Our most current Notice at any time.

B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: Dr. Michael F. Kelley, Clock Tower Dental Associates, 110 New Hyde Park Road, Franklin Square, N.Y. 10010 (516) 352-1000

Our Duties

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of this notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this notice, we will notify you in writing and provide you with a paper copy of the new notice, upon request.

Complaints

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by writing to out privacy official at the address that follows. We will not take any action against you for filing a complaint.

How to Contact Us

If you would like further information about our privacy practices, please contact

Dr Michael F. Kelley_____ at the following office address
110 New Hyde Park Road, Franklin Square, N.Y.

Phone #(516) 352-1000

Effective Date of Notice; April 1, 2003

Clock Tower Dental Associates, P.C.

Michael F. Kelley, D.D.S.
Richard Nejat, D.D.S.

Ramin Rayhan, D.D.S.
Jeffrey Kim, D.D.S.

110 New Hyde Park Road
Franklin Square, NY 11010
Telephone: (516) 352-1000
Facsimile: (516) 352-1059
www.clocktower-dental.com

I understand that Clocktower Dental has agreed to collect any part of their fee directly or indirectly from a second party, such as an Insurance Company or Union, that it is a courtesy and not an obligation. If the second party should cease to make payments, or downgrade any services rendered, or fail to make payments in a reasonable and timely manner I will be responsible for the unpaid balance. In addition, it is my responsibility to monitor my benefits for any changes or services left on my insurance while under treatment at Clocktower Dental.

Signature_____Date_____