Today's Date: : www.rochesterdental.com

JESSICA Y. CHEN, DDS, MS
2070 LYELL AVENUE, SUITE 200, ROCHESTER, NY 14606

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	❑ Dr. ❑	Marital status (circle one) Single / Mar. / Div. / Sep. / Wid.

Wish to be called:	Occupation:	Date of Birth: / /	Age:	Sex: ❑ M ❑ F
Street address:		City:	State:	ZIP Code:
E-mail:		Home Phone: Cell Phone: Work Phone:		

Preferred method of contact? ❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ E-Mail	Best time to call? ❑AM ❑PM ❑ Mon ❑ Tue ❑ Wed ❑ Thurs ❑ Fri ❑ Sat	Referred by(who we thank for):

RESPONSIBLE PARTY INFORMATION

Name:	Date of birth: / /	Social Security No.: Driver's License No.:	Relationship to Patient:
Street Address:	City:	State:	ZIP Code:

Employer Name:	Place of Employment:	Occupation:

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name:	Policy No.:	Policy Group No.:

Subscriber's Name:	Subscriber's Relationship to Patient:
Subscriber's Social Security No.:	Subscriber's Date of Birth: / /

Secondary Insurance

Insurance Co. Name:	Policy No.:	Policy Group No.:

Subscriber's Name:	Subscriber's Relationship to Patient:
Subscriber's Social Security No.:	Subscriber's Date of Birth: / /

MEDICAL INFORMATION

Primary Physician Name:	Phone No.:	
Previous Dentist Name:	Last Dental Visit: / /	Last X-ray Taken / / (bring them with you) (or forward them to us)

Medical Issues we should be aware of:

Do you have allergies? ❑ Yes ❑ No
If yes, specify:

Premed before dental visits? ❑ Yes ❑ No	Any current dental concerns?

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to Patient:	Home Phone No.:	Work Phone No.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to my dentist. I understand that I am financially responsible for any balance. I also authorize JESSICA Y. CHEN, DDS, MS or insurance company to release any information required to process my claims.

Patient/Parent/Guardian's Signature *Date*

Medical History

Patients Name__________________________________

1. When was your last physical examination? ______________ Physician ____________________ Phone ___________________
2. Are you being treated by a physician? Yes No If yes, please explain ____
____
3. Has there been any change in your health in the last year? Yes No If yes, please explain __________________________
____
4. Have you experienced any illness, accident, surgery or hospitalization in the past 5 years? If yes when and where? ___________
____
5. Have you ever has a serious head and neck injury? Yes No If yes, Explain ______________________________________
____
6. Do you use tobacco (smoke, chew), Marijuana, or drink alcohol daily? (Specify) ____
7. Do you use controlled substances? Yes No (Specify) ____
8. Are you or have you taken in the past **osteoporosis medications** (Fosamax, Actonel, Boniva, Reclast, Other)? Yes No
____
9. Woman:
   Pregnant / trying to get pregnant? Yes No If Pregnant, how many weeks into your pregnancy? _____________________
   Taking contraceptives? Yes No If Yes, the name of the contraceptive ____
   Nursing? Yes No
10. DO YOU NEED **PREMED** BEFORE DENTAL APPTS? Yes No If Yes, for what condition? ________________________
____
11. Are you **allergic to** any of the following: Yes No
    Latex Penicillin Aspirin Codeine Local Anesthetics (Novocain) Metal Acrylic
    List all of the other medications or drugs you are **allergic to**: None ____
____
12. Do you have any unusual reaction to dental injections? Yes No If yes, explain ___________________________________
____
13. **List medications** (include Aspirin, over the counter medications and substitutes) you are currently taking and
    their dosages if you know: None ____
____
____

14. *Do* you have or *have you had* any of the following:

Condition	Yes	No	Condition	Yes	No
Heart Trouble/Pacemaker			Anemia/blood problems/severe bleeding		
Heart Attack			Blood transfusion		
Heart Murmur			High Cholesterol		
Chest Pain			Cancer		
Stroke			Tumors or growths		
Prosthetic joint replacement			Chemotherapy		
Rheumatic Fever			Immunosuppressive therapy		
AIDS, HIV (or been tested for)			Severe Infections		
Hepatitis A, B, C(or been tested for)			Pneumonia		
High or low blood pressure			Arthritis		
Tuberculosis			Seasonal Allergy, Asthma, Hay Fever		
Herpes or cold sores/Shingles			Headaches or ear aches		
Sexually transmitted disease			Back, neck or shoulder pain		
Kidney problems			Sinus or eye problems (Glaucoma)		
Dialysis			Fainting		
Diabetes, Type I or Type II			Epilepsy (Seizures)		
Liver Disease			Forgetfulness (Alzheimer's Disease)		
Thyroid problems			Depression/ADHD/ADD		
Gastro-intestinal problems (Acid reflux or Ulcer)			Psychiatric treatment		

15. Have you ever had any serious illness not listed above? Yes No If Yes, please specify ___________________________
____
16. Do you have dental pain or sensitivity today? Yes No If Yes, please specify ____________________________________
____
17. Does your gum bleed when you are brushing or flossing your teeth? Yes No If Yes, specify _______________________
18. Do you have any cosmetic dental concerns? Whitening, Straightening, Reshaping, Other ________________________________
19. Any comment or suggestion? ____
____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient (Parent or Guardian if Minor) ___________________________ **Date** ____________________

Signature of Doctor or Hygienist__________________________________ **BP: /** **Pulse:**

Jessica Y. Chen, DDS, MS 2070 Lyell Ave., Suite 200, Rochester, NY 14606 585-865-4674 585-621-8230 (Fax)

Jessica Y. Chen, DDS, MS
2070 Lyell Ave., Suite 200
Rochester, NY 14606

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 April 14, 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.

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 voice mail 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 $0.15 for each page, $25.00 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:	Sandy
Telephone:	585-865-4674
E-mail:	office@rochesterdental.com
Website:	www.rochesterdental.com
Address:	2070 Lyell Avenue, Suite 200, Rochester, NY 14606

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ____________________________________ I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

____ ___________________

Signature of Patient (Patient/Guardian for Minor Child) Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, 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)

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