UDC UNIVERSITY DENTAL CARE LLC

DR. LANNY S. RUBIN
61 LIVINGSTON AVENUE
NEW BRUNSWICK, NJ 08901
WORK: (732) 545-1268
FAX: (732 545-4613

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to assist you. We look forward to working with you in maintaining your dental health.

Patient Information:

Name ______________________________________ Date__________

SS# ________________________ DOB _______________ Age_____

Driver's Lic/State ID # _______________________________________

Address _______________________________________ Apt ________

City___________________________ State_______ Zip ____________

Home Phone __________________ Cell Phone ___________________

E-mail _______________________________ Sex ☐Male ☐Female

☐ I would like to receive correspondence via e-mail.

☐Single ☐Married ☐Long-Term Partner ☐Divorced ☐Widowed

Employment Status: ☐F/T ☐P/T ☐Retired

Employer_______________________ Occupation________________

City___________________________ State_______ Zip ____________

Student Status: ☐F/T ☐P/T ☐Not a Student

School____

City___________________________ State_______ Zip ____________

Emergency Contact:

Name ____________________________ Relationship_______________

Cell Phone ____________________ Other Phone

Financially Responsible Party:

Name ______________________________________ DOB__________

Relationship ________________________SS# ____________________

Driver's Lic/State ID # _______________________________________

Address _______________________________________ Apt ________

City___________________________ State_______ Zip ____________

Home Phone __________________ Cell Phone ___________________

E-mail _______________________________ Sex ☐Male ☐Female

☐ I would like to receive correspondence via e-mail.

☐Single ☐Married ☐Long-Term Partner ☐Divorced ☐Widowed

Employment Status: ☐F/T ☐P/T ☐Retired

Employer_______________________ Occupation________________

City___________________________ State_______ Zip ____________

Payment is expected at the time services are rendered, unless other arrangements have been made in advance. I understand that I am responible for payment regardless of whether my insurance pays or not.

Method of Payment ☐ Cash ☐ Check ☐ Credit Card

Signature___________________________________ **Date**___________

Primary Dental Insurance:

Insurance Company____

ID#________________________ Group #___________________________

Address_________________________________ Phone_____________

City___________________________ State_______ Zip ____________

Subscriber's Information:

Name ___________________________________ ☐Male ☐Female

DOB______________________ SS#_____________________________

Relationship ☐Self ☐Spouse ☐Child ☐Other__________________

Address_________________________________ Phone_____________

City___________________________ State_______ Zip ____________

Employer ____

Address_________________________________ Phone_____________

City___________________________ State_______ Zip ____________

Additional Dental Insurance:

Insurance Company____

ID#________________________ Group #___________________________

Address_________________________________ Phone_____________

City___________________________ State_______ Zip ____________

Subscriber's Information:

Name ___________________________________ ☐Male ☐Female

DOB______________________ SS#_____________________________

Relationship ☐Self ☐Spouse ☐Child ☐Other__________________

Address_________________________________ Phone_____________

City___________________________ State_______ Zip ____________

Employer ____

Address_________________________________ Phone_____________

City___________________________ State_______ Zip ____________

ASSIGNMENT & RELEASE:

I hereby authorize payment directly to University Dental Care, LLC for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the doctor of UDC and/or any provider or supplier in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature____________________________________ **Date**________________

DENTAL HISTORY

Reason for Today's Visit ____________________

Former Dentist ____________________

Address ____________________ Phone ____________

City ____________ State ______ Zip ________

Date of last dental care ____________ Date of last x-ray ____________

How often do you brush? ____________ Floss? ____________

How do you feel about your current smile? ____________________

____

Do you have, or have had, any of the following problems? ***(Please check Y or N for each one)***

	Y	N		Y	N		Y	N		Y	N
Bad breath	☐	☐	Sensitivity to heat	☐	☐	Periodontal treatment	☐	☐	Jaw, head or neck injuries	☐	☐
Tooth Pain	☐	☐	Sensitivity to cold	☐	☐	Orthodontic Treatment	☐	☐	Grinding or clenching teeth	☐	☐
Loose teeth	☐	☐	Pain around ear	☐	☐	Frequent headaches	☐	☐	Blisters on lips or mouth	☐	☐
Broken filling	☐	☐	Finger nail biting	☐	☐	Sensitivity to sweets	☐	☐	Food colleciton between teeth	☐	☐
Bleeding gums	☐	☐	Lip or cheek biting	☐	☐	Sensitivity when biting	☐	☐	Jaw difficulty: Clicking and/or pain	☐	☐

MEDICAL HISTORY

Physician's Name ____________________ Phone ____________ Date of last visit ____________

Are you under a physician's care now? Y ☐ N ☐ If yes, please specify ____________________

Have you ever been hospitalized or had a major operation? ☐ ☐ If yes, please specify ____________________

Do you use tobacco? ☐ ☐

Do you use alcohol, cocaine, or other drugs? ☐ ☐

Do you wear contact lenses? ☐ ☐

WOMEN ONLY: Are you pregnant/trying to get pregnant? Y ☐ N ☐

Taking oral contraceptives? ☐ ☐

Nursing? ☐ ☐

Have you ever had any of the following? ***(Please check Yes or No)***

	Y	N		Y	N		Y	N		Y	N
AIDS or HIV	☐	☐	Circulatory Problems	☐	☐	Herpes	☐	☐	Scarlet fever	☐	☐
Anemia	☐	☐	Congenital heart lesions	☐	☐	High blood pressure	☐	☐	Shortness of breath	☐	☐
Arthritis, Rheumatism	☐	☐	Cortisone treatments	☐	☐	Jaundice	☐	☐	Sinus trouble	☐	☐
Artificial heart valves	☐	☐	Cough, persistent or bloody	☐	☐	Kidney disease	☐	☐	Skin rash	☐	☐
Asthma	☐	☐	Diabetes	☐	☐	Liver disease	☐	☐	Stroke	☐	☐
Back problems	☐	☐	Emphysema	☐	☐	Low blood pressure	☐	☐	Swelling of feet/ankles	☐	☐
Bleeding disorders	☐	☐	Epilepsy	☐	☐	Mitral valve prolapse	☐	☐	Swollen neck glands	☐	☐
Blood disease	☐	☐	Fainting or Dizziness	☐	☐	Nervous problems	☐	☐	Thyroid problems	☐	☐
Bone disorder	☐	☐	Glaucoma	☐	☐	Pacemaker	☐	☐	Tonsillits	☐	☐
Cancer, type ________	☐	☐	Headaches	☐	☐	Psychiatric care	☐	☐	Tuberculosis	☐	☐
Chemical dependency	☐	☐	Heart murmur	☐	☐	Radiation treatment, when ________	☐	☐	Tumor/growth of head/neck	☐	☐
Chemotherapy, when ______	☐	☐	Heart problems	☐	☐	Respiratory disease	☐	☐	Ulcer	☐	☐
Chronic fatigue syndrome	☐	☐	Hepatitis, type ________	☐	☐	Rheumatic fever	☐	☐	Venereal disease (STD/STI)	☐	☐

Are you allergic to any of the following?

☐ Aspirin ☐ Penecillin ☐ Local Anesthetics ☐ Sulfa Drugs ☐ Latex ☐ Other ____________________

Are you taking any of the following?

	Y	N		Y	N		Y	N
Anticoagulants/Blood thinners	☐	☐	Tranquilizers	☐	☐	Digitalis/Inderal/Nitroglycerin/Other heart drugs	☐	☐
Aspirin/Motrin/Aleve/Ibuprofen	☐	☐	Steroids	☐	☐	Insulin or oral anti-diabetic drugs	☐	☐
High blood pressure medications	☐	☐	Antibiotics	☐	☐			

Please list any and all medications you are currently taking, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:

____

____

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? Y ☐ N ☐

Do you take, or have taken, Phen-Fen or Redux? Y ☐ N ☐

AUTHORIZATION:

I understand the importance of a truthful health history to assist the doctor to provide the best care possible. I have had the opportunity to discuss my health history with my doctor.

I authorize and give consent to perform dental services agreed between University Dental Care, LLC and patient and/or legal guardian to be necessary or advisable including the use of anesthesia and other medications as indicated. I certify to the accuracy of the above statements regarding my dental and medical history. Payment for all treatment and services rendered are my responsibility.

Signature ____________________ **Date** ____________

OFFICE USE ONLY:

Completetion Reviewed By ____________

UDC University Dental Care LLC

Dr. Lanny S. Rubin
61 Livingston Avenue
New Brunswick, NJ 08901
work: (732) 545-1268
fax: (732 545-4613

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.

University Dental Care understands that medical information about you and your health is personal, and we are committed to protecting your medical information. Individually identifiable information about your past, present or future health or conditions, the provision of health care to you, or payment for such health care is considered "Protected Health Information" ("PHI").

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 January 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. In the event we make a material change in our privacy practices, we will change this Notice and post a copy in our office and on our website www.universitydentalcare.org. The effective date of the Notice is provided above.

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 the Privacy Officer whose information is provided at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may 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 dentist or other healthcare providers providing treatment to you for: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Payment: We may use and disclose your health information to obtain payment for services we provided to you. This may include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determination of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursements.

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

To You, Your Family, Friends, and Other Persons Involved in Your Care: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information with a family member, friend or other person identified by you that is directly related to that person's involvement in your care or payment for you care, or to notify such individuals of your location or general condition, but only if you agree that we may do so, or, based on our professional judgment, we determine that you would not object to the disclosure. We will also use our professional judgment and our experience in allowing a person to pick up supplies, x-rays, or other similar forms of health information on your behalf.

Persons Involved in Care: We may disclose your 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 health care. 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 Products or Services: We will not use your health information for marketing communications without your prior written authorization. We may provide you with information regarding products or services that we offer related to your health care needs. We will never sell your health information without your prior authorization.

Use and Disclosure of Health Information Required by Law: We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by state worker's compensation laws.

Health-Related Services: We may use and disclose your health information to send you information by mail or email about our health-related products and services available to you, general dental health news and information, and offers available only to our patients. We will tell you how to cancel these communications.

Contacting You: We may use and disclose your health information to contact your about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, email, or mail. We may leave you messages at the telephone number you give us.

Appointment Reminders and Treatment Alternatives: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, e-mails, postcards, or letters) or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Your Authorization: As explained in this Notice, we may use and disclose your health information for treatment, payment, or health care operations; in certain situations if you agree or object; as required by law; to contact you; and to send you health-related information, be we cannot use or disclose your health information for any other reason without your written authorization. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures already made with your authorization while it was in effect.

Patients Rights

Right to Access Your Health Information: You have the right to review 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 practically 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. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of our denial. We may charge you a fee for expenses such as copies, staff time, and postage. If you prefer, we will prepare a summary or an explanation of your health information for a fee, only if you agree in advance to the form and fee of the summary or explanation. Contact us using the information listed at the end of this Notice for a full explanation for our fee structure.

Right to Accounting of Disclosures of Your Health Information: 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, and healthcare operations, and certain other activities for the last 6 years, but not for disclosure made prior to April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a fee for responding to these additional request. You must submit a written request that is signed and dated. Your request must be written to the Privacy Officer whose information is provided at the end of this Notice.

Right to Request Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and healthcare operations, and to family members, friends, or others involved in your care or payment for your care. You must submit a written request that is signed and dated to the Privacy Officer whose information is provided at the end of this Notice. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in certain situation, such as to provide you with emergency treatment).

Right to Request Alternative Communications: You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations. For example, you can ask that we only contact you at work, or only by mail. You must submit a written request that is signed and dated to our Privacy Officer whose information is provided at the end of this Notice. 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.

Right to Request Amendment: You have the right to request that we amend your health information. You must submit a written request that is signed and dated to our Privacy Officer whose information is located at the end of this Notice. Your request must explain why your health information should be amended. If we deny your request, we will respond to you in writing with the reason we cannot grant your request and explain your options.

Right to Written Notice: If you receive this Notice on our website or by email, you are entitled to receive this Notice in written form.

QUESTION 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 have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services.

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.

PRIVACY OFFICER

Should you wish to contact the Privacy Officer, you may do so at the address and telephone number below.

Privacy Officer
61 Livingston Avenue
New Brunswick, NJ 08901
Telephone: (732) 545-1268

UDC UNIVERSITY DENTAL CARE LLC

DR. LANNY S. RUBIN
61 LIVINGSTON AVENUE
NEW BRUNSWICK, NJ 08901
WORK: (732) 545-1268
FAX: (732 545-4613

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT (HIPAA)

Please Review the Notice of Privacy Practices before completing this Form.

SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Name: ______________________________ Social Security #: ______________ Telephone: __________________

Address: ____________________________________ City_________________________ State_____ Zip_________

E-mail: ____

SECTION B: TO THE PATIENT/GUARDIAN (*PLEASE READ THE FOLLOWING STATEMENT CAREFULLY*)

Purpose of Consent: By signing this form, you will consent to the use and disclosure of your protective health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign this Consent Form. Our Notice provides a detailed description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent Form. We encourage you to read it carefully and completely before signing this Consent Form. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time through our website www.universitydentalcare.org or by contacting Privacy Officer whose information is provided below:

Privacy Officer
61 Livingston Avenue
New Brunswick, NJ 08901
(732) 545-1268

Acknowledgement of Receipt:

I, ___________________________ (*print name*) have received acknowledgement of this office's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of this Consent form and have been offered a chance to obtain the Notice of Privacy Practices for me to review. I understand that by signing this Consent form, I am giving my consent to University Dental Care, LLC use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: ______________________________ **Date:** __________

☐ YES, I would like a copy. ☐ NO, I do not want a copy.

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name:_________________________ **Relationship to Patient:**_____________________

SECTION C: Patient's Right to Revoke Consent

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Privacy Officer whose information is listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Revocation of Consent: I revoke my Consent for University Dental Care, LLC use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my Consent.

Signature: ______________________________ **Date:** __________

OFFICE USE ONLY:
Completetion Reviewed By __________

UDC University Dental Care LLC

Dr. Lanny S. Rubin
61 Livingston Avenue
New Brunswick, NJ 08901
work: (732) 545-1268
fax: (732 545-4613

Dental & Medical Insurance Consent:

Insurance does not always cover the full cost of dental care. Insurance coverage is designed to reduce your cost, not eliminate it. It is your responsibility to know and understand your insurance policy and the coverage of benefits it provides. We will submit your insurance claim to your dental and medical insurance company(s) as a courtesy to you. This does not imply or guarantee that your particular plan will cover your anticipated procedure, either in part or in full. We require that you pay any deductible, copayments, and fees over you annual maximum at the time services are rendered. If the processing of your claim has been delayed, we request your assistance in expediting the process. After 90 days your outstanding balance is due regardless of the status of your insurance claim.

After you claim has been processed by your insurance company(s), University Dental Care, LLC will contact you regarding any unpaid balance. We will also send you a statement. The payment is due within 30 days of the statement date. In the event your account is placed with an agency for collection purposes, you will be responsible for all collection agency fees (up to 30% of the balance placed for collection). In addition, you will be responsible for all court costs, filing fees, and attorney fees should your account require litigation.

*****Estimated patient financial responsibility is due at the time of service*****

Please initial on each line.

_______ I acknowledge that it is my responsibility to know and understand my insurance policy(s) and the coverage of benefits it provides. I agree to be responsible for all charges for dental/medical services and materials not paid by my insurance plan(s), unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. I consent to allow University Dental Care, LLC to use and disclose my protected health information to carry out any activities in connection with my insurance claims.

_______ I hereby authorize all practitioners of University Dental Care, LLC to provide any insurance company(s), claim administrator(s), and consulting healthcare professional(s) information concerning healthcare, advice, treatment or supplies utilized during my procedure. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I understand and accept that UDC submits claims electronically.

_______ I understand the terms stated herein are to remain in effect throughout my treatment with University Dental Care, LLC.

_______ By signing this section, I authorize payment of insurance benefits directly to University Dental Care, LLC.

Signature____ **Date**________________

OFFICE USE ONLY:

Completetion Reviewed By _____________