CONFIDENTIAL

Patient Registration Information

Date_____

Name_____ Patient #_____
First Mi Last

Welcome to our practice!

Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance-we will be happy to help!

Home address_____ City_____ State/Prov._____ Zip/P.C._____

Birthdate_____ Home Phone_____ Work Phone_____

E-Mail_____ Cell Phone_____

Do you prefer to receive calls at: ☐ Work ☐ Home ☐ Either

Are you: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Your or your parent/guardian's employer_____ Occupation_____

Business address_____ City_____ State/ Prov._____ Zip/ P.C._____

Spouse or parent/guardian's name_____ Employer_____ Work phone_____

If you are a student, name of school/college_____ City_____ State/ Prov._____

Whom may we thank for referring you? _____

Person to contact in case of an emergency_____ Phone_____

Responsible Party

Name of person responsible for this account_____ Relationship_____

Address _____ Home Phone_____

City_____ State/ Prov._____ Zip/ P.C._____ SS #/SIN_____

Driver's license #_____ Birthdate_____ Financial institution_____

E-Mail_____ Cell Phone_____

Employer_____ Work phone_____

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of insured_____

Relationship to patient _____

Birthdate_____ SS #/SIN_____ Date employed_____

Employer_____ Work phone_____

Address of employer_____ City_____ State/ Prov._____ Zip/ P.C._____

Insurance company_____ Group #_____ Employer/cert. #_____

Ins. co. address_____ City_____ State/ Prov._____ Zip/ P.C._____

How much is your deductible?_____ How much have you used?_____ Max. annual benefit?_____

Please Continue... ☞

Additional Insurance

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured _____

Relationship to patient _____

Birthdate _____ SS #/SIN _____ Date employed _____

Employer _____ Work phone _____

Address of employer _____ City _____ State/ Prov. _____ Zip/ P.C. _____

Insurance company _____ Group # _____ Employer/cert. # _____

Ins. co. address _____ City _____ State/ Prov. _____ Zip/ P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Authorization, Release, and Agreement to Pay For Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental 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 on behalf of my dependents.

X _____ _____

Signature of patient or parent/guardian if minor Date

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance.

Payment in full at each appointment

_____ Cash

_____ Personal Check

_____ Credit Card _____ Visa _____ MasterCard

Card # _____ Expiration Date _____

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help.

If this claim is accident related, please provide details of the accident: _____

Did you sustain an injury at work?
☐ Yes ☐ No

Are you covered under an employer or union policy?
☐ Yes ☐ No

Are your injuries accident related?
☐ Yes ☐ No

Is your spouse or other family member employed?
☐ Yes ☐ No

Are you currently employed?
☐ Yes ☐ No

Do you have a secondary or medical insurance policy?
☐ Yes ☐ No

Have you ever served in the military?
☐ Yes ☐ No

Are you covered under any other healthcare plan?
☐ Yes ☐ No If so Name _____ and # _____

Medical History: Do you have or had any of the following (check all that apply)

☐ AIDS
☐ Anemia
☐ Arthritis/Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joints
☐ Asthma
☐ Back Problems
☐ Bleeding Abnormalities
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory problems
☐ Congenital Heart Lesions
☐ Cortisone Treatments
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart Murmur
☐ Heart Attack
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ HIV
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Psychiatric Care/Problems
☐ Radiation Treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Shortness of Breath
☐ Skin Rash
☐ Sinus Problems
☐ Stroke
☐ Thyroid Problems
☐ Tobacco Habit
☐ Positive Tuberculosis

Are there any other health conditions you have that are not listed?
If so, please explain: _____

Please List all Allergies: _____
Please List all Medications You are Taking:

Women Only:
Are you Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Had an exposure to HPV? ☐ Yes ☐ No

Date of Last Dental Exam: _____ Reason for Today's Visit: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. **This information will be kept confidential.**

_____ _____
Signature Date

Effective April 14, 2003

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. You may be aware that U.S. government regulators established a privacy rule ("HIPAA") governing protected health information. This notice tells you about how it may be used, and about certain rights that you have.

Dr. Tomas A. Torres is in charge of privacy matters at our office. You can contact him at (845) 294-7040 if you desire further information, or have any questions or concerns.

Use and Disclosure of Protected Information

Federal law provides that we may use your health information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you. For example, if we refer you to a specialist, we may provide x-rays, laboratory or test data to that specialist (subject to more stringent New York laws, such as restriction on disclosure of information concerning HIV/AIDS)

Federal law provides that we may use your health information to obtain payment for our services without further specific notice to you, or written authorization by you. For example, our accountants may see your name, dates of treatment and procedure codes during audits of our books.

We may use or disclose your health information, without further notice to you, or specific authorization by you, where:

1. Required by law;
2. Required for public health purposes;
3. Required by law to report child abuse;
4. Where required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline of Office of Professional Medical Conduct;
5. Required by law in judicial or administrative proceedings;
6. Required for law enforcement purposes by a law enforcement official;
7. Required by a coroner or medical examiner;
8. Permitted by law to a funeral director;
9. Permitted by law for organ donation purposes;
10. Permitted by law to avert a serious threat to health or safety;
11. Permitted by law and required by military authorities if you are a member of the armed forces of the United States;
12. Research purposes or public health purposes after being de-identified or limited to remove personally identifiable information;

New York State law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information.

We may need to contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make reasonable requests, in writing, for us to use the alternative methods for communicating with you in a confidential manner. Space for this is provided below.

Other uses or disclosures of your health information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Rights that you have

You have the right to request restrictions on certain uses of the disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your health information (a reasonable fee will be charged).

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make of your health information, except for: disclosures we make to you, or to carry out treatment, payment or health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR §164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law, or for research or public health purposes after begin de-identified or limited to remove personally identifiable information, or disclosures made before April 14, 2003.

You have the right to obtain a copy of this notice from our office.

Obligations that we have

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

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. Complaints should be directed to: Dr. Tomas A. Torres, D.D.S., PO Box 869, 29 Saint John Street, Goshen, New York 10924, (845) 294-7040.

No retaliatory action will be taken against you for any complaint you may make.

I make the following special request for confidential communications:

Signature _____ Print Name _____ Date _____

Tomas A. Torres, D.D.S., P.C.

TOMAS A. TORRES, D.D.S., P.C.
301 MAIN STREET, SUITE C
GOSHEN, NEW YORK 10924

Phone: (845) 294-7040

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT
We now offer the following payment options:

___ Payment by cash

___ Payment by check

___ Payment by credit card

___ Automatic monthly billing to your Visa or MasterCard

___ Guarantee any amount not covered by insurance with Visa or MasterCard.

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see the office manager. Thank you.

_____
Print your name here and sign below

*x*_____
*Date:*_____

Dr. Tomas A. Torres Jr., DDS
301 Main Street, Ste. C, Goshen, New York 10924
(845) 294-7040

Financial/Appointment Agreement

We would like to welcome you and your family to our office. We are committed to providing you with the best possible dental care. To provide the most beneficial and comprehensive treatment and service, we ask that you review and complete our office policy/financial policy agreement consent forms. We will gladly discuss your proposed treatment, financial options, and any other questions you may have. Our goal is to keep you informed and involved with your treatment as much as possible.

Dental Insurance

If you have dental insurance, we will gladly prepare and file the claims as a courtesy to you. We do ask that the correct insurance information be provided at the time of your appointment in order for us to timely submit claims and collect payments. If this information changes, it is the patient's responsibility to update our office at the earliest convenience. While we do our best to verify coverage and benefits prior to your first appointment, this does NOT guarantee coverage or payments to this office.

Our office will gladly provide you with an ESTIMATE of your out of pocket expense for any dental treatment planned by the doctor. However, please understand that these are strictly estimates and are not a guarantee that your insurance company will reimburse us according to those estimates. So that there are no surprises, we strongly suggest that you familiarize yourself with your particular dental insurance coverage and benefits, and keep in mind that our dental services are rendered to you, not your insurance company. Therefore, you are personally and directly responsible to us for the obligation of payment of fees. Your insurance company, of course, is responsible to you.

Please note that any difference in payment from the contracted fee schedule of your insurance company and your account balance is YOUR responsibility.

Treatment Plans/Pre-Authorizations

For treatment involving major work, most insurance companies require us to submit for pre-authorization. This involves the submission of a plan of your proposed treatment, x-rays relating to the proposed treatment, and any other documentation required by your insurance company. This process can take from 2 to 4 weeks, but can possibly take longer. The insurance company takes this time to review your treatment plan and either approves, denies, or asks for more documentation supporting the need for proposed treatment from our office. When we receive your pre-authorization, we will call you to discuss the results including your financial responsibility and then make you an appointment to begin treatment.

In the event that emergency treatment is chosen to be initiated without the time for prior approval by insurance, such as a broken tooth that needs a crown, or a broken crown/denture, please understand that until insurance approves treatment, the balance due remains the responsibility of the patient.

For patients with or without dental insurance coverage: Treatment that requires fabrication by a laboratory, such as crowns, bridges, dentures and partials, a 50% deposit will be required at the start of treatment. The remaining balance will be due upon completion of work.

In the event that the doctor refers you for treatment with a specialist such as an oral surgeon, endodontist, or periodontist, please notify our office when treatment is completed.

Payment, Co-Pays, and Deductibles

In an effort to keep our costs to a minimum, payment for services **including co-pays and deductibles** is due at the time treatment is provided. We have several options for payment of treatment, which may be paid in the following manner:

1. Payment by cash, check, or Visa/Mastercard
2. Payment by Care Credit. Care Credit is bank financing for qualified applicants who prefer additional time to pay their balance. It is designed to meet the needs of our patients and is ideal for extended treatment plans, elective procedures, emergency care, and treatment not covered by insurance. Care Credit has financing options available that include 6 and 12 month interest free payment plans, as well as an extended payment plan depending on qualifications.

Appointments/Missed Appointments

It is very important to us to do the best we can to stay on schedule, not only for the needs of our patients, but for the needs of our practice as well. Despite careful scheduling, emergencies can sometimes cause delays. If your appointment is effected due to an unforeseen dental emergency, we will do what we can to notify you. We know that your time is very valuable, but please know that you will receive the same quality dental care no matter how our schedule is running. We also understand that from time to time an emergency will arise and you may be late or miss an appointment altogether. If you are going to be late or are not able to make an appointment, please call us and let us know as soon as you can. **If an appointment is cancelled without at least 24 hours notice, a $50 per hour charge will be added to your account. We do this not as an inconvenience to you, but because we cannot afford to lose valuable treatment time.** Our message system will accept your cancellation calls for you and will record time/date of your calls to avoid a charge to your account. We appreciate your efforts to keep scheduled appointments and we will make every effort to continue to have convenient hours and prescheduled availability for you.

Regarding appointments for children; for unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with our office.
The accompanying parent or guardian of minor children is responsible for any payment due.

Emergency Appointments

In the event of a dental emergency, we will do our very best to schedule you as soon as possible the same day. Please understand, however, that emergency patients will be worked into an already existing daily schedule. We can not guarantee that any dental treatment will be initiated, but we will address your needs by doing an examination and possibly taking an x-ray. If you are in pain, the doctor will discuss pain management with you and prescribe any necessary medication.

I have reviewed and agree to the above information_____