

ADVANCED DENTAL SPECIALTY
CONSENT FORM USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

NAME: _____

ADDRESS: _____

TELEPHONE: (_____) _____/_____

EMAIL: _____

Section B: TO THE PATIENT PLEASE READ THE FOLLOWING STATEMENT CAREFULLY

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities and healthcare options.

NOTICE OF PRIVACY PRACTICES: You have the right to read our notice of privacy practice before you decide this consent. Our notice provides a description of our treatment payment activities and healthcare operation of the uses and disclosure we may make of your protected health information mater about your protected health information. A copy of our notice accompanys this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practice as describe in our notice of privacy practices. If we change our privacy practice we will issue a revised notice of privacy which will contain the change those changes may apply to any of your protected health information that we maintain.

You obtain a copy of our notice of privacy practices including any revisions of our notice at any time by contacting:

Contact person: Alice Cedenó

Address: 237 Willis Avenue Bronx NY, 10454

Phone: (718) 292-6209 / (718) 292-8988, fax :(917) 792-7979

Email: dds@bronxadvanced.com

RIGHT TO REVOKE: you will have the right to revoke this consent at any time by giving us writing notice of your revocation submitted to the contact person listed above. Please understand that by signing this consent payment activities and health care operations.

Signature: _____ **Date:** _____

If this consent is signed by a personal representative on behalf of the patient complete the following :

Personal representative's name: _____

Relation to the patient: _____

Section C: ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____, have received a copy of this offices

Notice of Privacy Practices.

Signature: _____ **Date:** _____

ADVANCED DENTAL SPECIALTY

Today's date: ____ / ____ / ____

Patient Name: _____ D.O.B: ____ / ____ / ____

Address: _____ apt# _____ State : _____ ZIP _____

Please answer all questions correctly in order for the dentist to better plan for you treatment.

Please answer all questions by CIRCILING either YES or NO. CIRCULE SI o NO.

1.	Are you under the care of a physician at the present time?	Yes	No
	<i>Esta bajo tratamiento de un medico?</i>	<i>Si</i>	<i>No</i>
1.	Are you presently taking medication?	Yes	No
	<i>Esta usted tomando medicinas recetadas ultimamente?</i>	<i>Si</i>	<i>No</i>
2.	Have you ever been told you have trouble with your heart?	Yes	No
	<i>Le han dicho alguna vez que padece del Corazon?</i>	<i>Si</i>	<i>No</i>
3.	Has a physician ever told you that you have High Blood Pressure?	Yes	No
	<i>Le ha dicho el medico alguna vez que tiene la Presion Alta?</i>	<i>Si</i>	<i>No</i>
4.	Do you have a heart murmur?	Yes	No
	<i>Tiene usted un soplo en el Corazon?</i>	<i>Si</i>	<i>No</i>
5.	Have you ever had or do you now have any infectious disease such us AIDS,Hepatitis,other?,	Yes	No
	<i>Tiene o ha tenido enfermedades infecciosas como SIDA, HEPATITIS O OTRAS</i>	<i>Si</i>	<i>No</i>
6.	Do you have allergies?	Yes	No
	<i>Tiene Alergias?</i>	<i>Si</i>	<i>No</i>
7.	Are you allergic to any drugs?	Yes	No
	<i>Allergico/a alguna medicina?</i>	<i>Si</i>	<i>No</i>
8.	Do you have any prosthetic joints or heart valves?	Yes	No
	<i>Tiene usted protesis en sus articulaciones o valvulas metalicas en el Corazon?</i>	<i>Si</i>	<i>No</i>
9.	Do you have diabetes?	Yes	No
	<i>Tiene Diabetes?</i>	<i>No</i>	<i>No</i>
10.	Do you have any bleeding problems? Prolonged bleeding following tooth extractions or cuts?	Yes	No
	<i>Sangra con Facilidad?</i>	<i>No</i>	<i>No</i>
11.	Have you had previous extractions with Local or General Anesthesia or Gas?	Yes	No
	<i>Ha Tenido extraciones anteriores con anesthesia general o local ,o gas?</i>	<i>Si</i>	<i>No</i>
12.	Have you ever had any trouble of any type when you had a tooth removed?	Yes	No
	<i>Ha tenido problemas anterior cuando ha tenido extracion ?</i>	<i>Si</i>	<i>No</i>
13.	Have you ever been treated with Cortisone or with Radiation (X-Ray)?	Yes	No
	<i>Ha estado tratado con cortisone o con radiacion?</i>	<i>Si</i>	<i>No</i>
14.	Have you had a venereal disease?	Yes	No
	<i>Ha tenido una enfermedad venerea?</i>	<i>Si</i>	<i>No</i>
15.	Have you ever had any operations or major surgery, serious illness, or been hospitalized for a long length of time?	Yes	No
	<i>Ha tenido alguna operacion o cirugia mayor, enfermedad grave o sido hospitalizado por un largo periodo?</i>	<i>Si</i>	<i>No</i>
16.	Are you PREGNANT?	Yes	No
	<i>Estas embarazada?</i>	<i>Si</i>	<i>No</i>
17.	Have you ever had tuberculosis, asthma or other lung troubles, liver, gall bladder, anemia, or epileptic convulsions?	Yes	No
	<i>Alguna vez has tenido tuberculosis, asma u otros problemas pulmonares, higado, vesicular biliar, anemia o convulsions epilepticas?</i>		<i>No</i>
18.	Are you smoker? Fuma?	Yes	No

Patient Signature: _____