Dr. Gary Ruth
30 Central Park South
Suite 5- C
New York, NY 10019

Patient Information

Patient Name:_______________________________________ **Date:**__________
Last, First MI (Preferred Name)
Gender: __________ **Family Status:**__________

Birth Date:____________________ **Social Security #:**____________________

Phone (Home):__________ (Work):__________ Ext:______ (Cellular): __________

Address: ____
Street **Apartment #**
____ ***E-Mail :***____________________
City State Zip Code

Have you, or another family member been seen in our office in the past?__________________

Health Information

Reason for this visit: __________ **Pharmacy (Name and Number) :**__________

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies __________
  - ☐ Codeine Allergy
  - ☐ Penicillin Allergy
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy**
  Due date:__________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Osteoporosis

OTHER:
☐ __________________

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you now under the care of a physician? ☐ Yes ☐ No If yes, name of physician __________________
  If yes, please explain: ____
- Please list All Medications presently taking : ____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: __________________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other __________________

Name of person or office referring you to our practice: ____

Insured or Responsible Party Information

The following is for: ☐ the insured ☐ the person responsible for payment

Name:____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other __________

Birth Date : ____________________ Social Security # : ____________________

Phone (Home): ____________ (Work): ____________ Ext: ______ (Cellular): ____________

Address: ____

Street Apartment #

____

City State Zip Code

Employer name and address

____

____

Insurance Information

Insurance Plan Name and Address:

Dental Insurance : ____________________

____

____

Insurance Plan Name and Address:

Medical Insurance : ____________________

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Note : Biopsy - Tissue removed will be sent to Oral Pathology Laboratory for microscopic examination. You will be billed directly by Oral Pathology Laboratory, this bill represents laboratory tests requested by your doctor.

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Note: General Anesthesia / I – V Sedation is an elective procedure which may not be covered by your Dental / Medical Insurance. Payment for this service is expected at the time of visit.

I hereby give my consent to Dr. Gary Ruth and staff, to perform the indicated oral surgery on me/ or my child ____________under local or general anesthesia.

Signature ____________________

Responsibility Statement

I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage. I allow the use of my credit/debit card on file for all charges whether or not paid by my insurance company, within 60 days of any unpaid balance.

Account No. ____________________

Exp. Date ____________ Visa Mastercard Amex Discover

Signature ____________________

Authorization and Release

I have read and answered the questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to receive the payment of benefits.

Signature ____________________ Date __________

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:__________________________ Signature______________________Date______

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Compliance assurance notification for our patients

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.