



James Michael Muzzi, DMD

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
 Last, First MI (Preferred Name) Gender: _____ Family Status: _____
 Social Security #: _____ Birth Date: _____
 Phone (Home): _____ (Work): _____ (Cell): _____ Email _____
 Insurance Carrier _____ Group # _____ Member ID: _____
 Address: _____
 Street Apartment #
 City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

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

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | OTHER: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | Medications: |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> _____ |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | _____ |

• 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, please explain: _____

• Name of Physician: _____ Phone: _____

• 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.

Signature of patient, parent or guardian Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Internet Insurance Company Social Media Work Other _____
 Name of person or office referring you to our practice: _____



Dr. James Michael Muzzi
General and Cosmetic Dentistry

SMILE EVALUATION

1. Do you like the way your teeth look? Yes No

Explain: _____

2. Are you happy with the color of your teeth? Yes No

Explain: _____

3. Would you like for your teeth to be whiter? Yes No

Explain: _____

4. Would you like your teeth to be straighter? Yes No

Explain: _____

5. Do you have spaces between your teeth that you would like closed? Yes No

Explain: _____

6. Would you like your teeth to be longer? Yes No

Explain: _____

7. Do you like the shape of your teeth? Yes No

Explain: _____

8. Do you have missing teeth that you would like to replace? Yes No

Explain: _____

9. Do you have old silver fillings that you would like to replace with tooth-colored fillings? Yes No

Explain: _____

10. If you could change anything about your smile, what would you change?

Explain: _____

James Michael Muzzi, DMD

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The following is an outline of our office payment policies. Please acquaint yourself with them and then sign below to acknowledge your understanding and acceptance of them.

FEES

Before any dental treatment begins, the patient and/or responsible party will receive a consultation regarding treatment plan and cost. We attempt to keep our fees at a fair level that reflects the quality of care provided in our office. Prompt payment will enable us to keep our fees lower for everyone; therefore, payment is due at the time services are rendered.

PAYMENT

We accept cash, check, American Express, Visa, MasterCard, and Discover. We also offer zero down payment/zero interest financing options thru a third party finance company. Please see reception for details.

INSURANCE

As a courtesy to our patients with insurance, we will file your insurance claim and allow you to pay only your deductible and/or estimated co-payment as services are rendered. Please remember that the contract is between you and your insurance company, and your total balance in our office is always your responsibility. We make every effort to give you an accurate estimate of what your portion of our fees will be, based on information provided to us. However, we have no way to guarantee the actual terms of your insurance policy. If for any reason there is a balance remaining after your insurance company's payment, you will be sent a statement. Disputes regarding reimbursement or the amount of reimbursement are between you and your insurance carrier.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, unless payment arrangements have been made in advance.

I grant my permission to you or your assignee, to telephone me to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of guarantor of payment/responsible party:

Signature: _____

Date:

Relationship to Patient:

Response Date:



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We purposely do not overbook our schedule in order to give our patients the most effective quality dental care. To make sure that we can better serve you, a time slot is fully guaranteed when you make an appointment with our office.

Therefore, **24 HOURS NOTICE IS REQUIRED TO CANCEL ANY APPOINTMENT.** If not, in fairness to all our valued patients and our own efficiency, we regret **WE MUST CHARGE A \$100.00 FEE WHICH CANNOT BE COVERED BY AN INSURANCE COMPANY.**

FAILURE TO SHOW UP FOR AN APPOINTMENT WITHOUT ADVANCED NOTICE REQUIRES THAT THE PATIENT BE RESPONSIBLE FOR THE FULL COST OF THE VISIT.

We have established this policy to help keep our costs down permitting us to pass along operational savings to you.

Individual health care is our goal and we look forward to supporting you in providing your maximum health needs.

Name: _____

Signature: _____

Date: _____



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General and Cosmetic Dentistry

NOTICE OF PRIVACY PRACTICES (Dental)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, to be kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We use and disclose your medical records for the purposes of treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer services. An example would be an internal quality assessment review.

We may also create and distribute re-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be interest to you.

Any other uses and disclosures will be made only your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relaying you your authorization.

You have certain rights in regards to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

The right to request restrictions on certain uses and disclosures to protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us By alternative means or an alternative locations.

The right to inspect and copy your protected health information.

The right to amend your protected health information.

The right to receive an accounting of disclosures of protected health information.

The right to obtain a paper copy of this notice from us upon request.

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

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health, and Human Services, Office of Civil Rights about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

James Michael Muzzi, DMD
614 Second Avenue, Suite D
New York, NY 10016

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll free)



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this
office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,
but acknowledgement could not be obtained because:

- Individual refused to sign
 - Communication barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Please Specify)
-

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form by any other party requires the prior written approval of the American Dental Association.

This form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

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