YOUR SYRACUSE

FAMILY DENTIST

VINCENT D. DIMENTO DMD

Welcome To

It is an honor and a compliment to have you as a patient!
Come in and Let Us Show You the Difference!

Thank you for taking the time to review our OFFICE POLICIES.
Please let us know if you have any questions or concerns. We are here to assist you.

Patients cannot be seen until all paperwork is read signed and completed
Minors must have a guardian signature

APPOINTMENTS:

- Any patient under the age of 18 must be accompanied by a parent for all appointments
- Reminder appointment phones calls/texts and 2-week reminder postcards are a courtesy to our patient's. Please understand it is your responsibility to know when your appointment is. If a message is left PLEASE call to confirm you received the message.
- Please help us to serve you better by keeping scheduled appointments. Kindly give 48 hrs for any cancellation. Non-emergency missed appointments/cancelled without sufficient notice can result in a fee.

EMERGENCY COVERAGE: Please contact our office. Our office has 24 hour coverage.

INSURANCE & FINANCIAL INFORMATION: We submit and file all of your insurance claims for you as a courtesy. Please verify with our office staff any questions pertaining to your insurance. We will gladly do a courtesy benefits check for you. Please notify us of ANY changes in your insurance coverage **PRIOR** to your visit. *Our office **does not** participate with Medicaid or Medicare or State Funded policies.*

If you have insurance, we will gladly help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of your insurance and our financial policy. Please ask if you are unsure of anything. We require a copy of ALL insurance identification cards and a copy of a patient's license or ID card.

Please be familiar with all your insurance terms and frequencies. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. (See our link on our web page for further information on area rates) *You are responsible for payment regardless of any insurance company's "arbitrary" determination of UCR (usual and customary rates) quote.*

Many insurance provider directories are not up to date and sometimes we cannot access that information as quickly as needed. We **MUST** emphasize that as medical care provider, our relationships is with you, **NOT your insurance company**. We will gladly submit all forms needed for a "pre" authorization for treatment to your insurance company for you. If an insurance carrier has not paid within 60 days of billing, any unpaid balances are due and payable in full from you immediately.

Cash, Check, Visa, MasterCard, American Express, Discover Card, Flex Account Cards, HSA, FLEX, Care Credit are gladly accepted

Dr DiMento also offers several different payment options plans, from short-term to long-term – please ask at front desk.

We will submit for insurance's providing:

- All patient forms are filled out and the information is correct and we have copies of Insurance Cards
- We are able to verify coverage by telephone or internet and have a complete mailing address and current phone number

Please be prepared at appointment time to pay your estimated patients responsibility portion not covered by your insurance. Please understand that payment of your bill is considered part of the treatment. Interest will accrue and will be added to all accounts over 60 days post insurance payment. Any disputes with balances due must be brought to our attention within 30 days of 1st billing.

We realize that temporary financial problems do arise and we encourage you to contact us promptly for assistance in the management of your account. To avoid any misunderstandings, we invite you to discuss any financial problems or hardship you may have with our office. Please inquire as to payment options that our office may offer.

ASSIGNMENT OF BENEFITS:

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree this authorization will cover all medical services rendered until such authorization is revoked by me in writing. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I will notify you of any changes in my health status or changes in my insurance status prior to appointments. In the event my account is assigned for collection, I agree to pay an additional collection fee – the greater of $25.00 fee or 30% collection fee based on the total amount overdue as well as any associated attorney fees.

PLEASE READ –SIGNATURE @ FRONT DESK ON SIGNATURE PAD WILL BE REQUIRED AT FIRST APPOINTMENT

Thank You & Have a FANTASTIC day ☺

Dr Vincent D DiMento DMD

Notice of Privacy Practices (HIPAA)

8-19-13

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. ***Example:*** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*

For Business Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Example:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

Your rights regarding your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Website Privacy

Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site.

Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches:

You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at *(Dr Vincent D DiMento, DMD).* If you have questions and would like additional information, you may contact us at **315.477.9960**

PLEASE READ –SIGNATURE @ FRONT DESK ON SIGNATURE PAD
WILL BE REQUIRED AT FIRST APPOINTMENT – thank you

YOUR SYRACUSE

FAMILY DENTIST

VINCENT D. DIMENTO DMD

WELCOME TO OUR PRACTICE

Thank you for choosing us. Our goal is to provide you with quality dental care and personal attention to ensure your continued good health. We are committed to providing our patients with state of the art care in a comfortable; relaxing and friendly environment. It is our goal to conduct a comprehensive review of your dental records in order to determine the proper treatment for you. After we finish gathering all pertinent information, Dr will review with you all findings. We will discuss all treatment in detail, including benefits, risks, and alternatives at a separate consultation visit. It is our desire for you to leave our office with a full understanding of your treatment and with all questions answered. Once we have determined the best treatment plan, our staff will assist you with any appointment and scheduling needs and attempt to assist you with any insurance questions you may have.
We look forward to meeting you & thank you for choosing us for your dental health needs ☺

REMINDER we will need any **current** X-rays you may have from a previous dentist, **prior to seating you.** (Current is <1yr old for Bite Wings or <3yr for Panoramic Film or <3 yr for Full Mouth Series).

Just a couple of items to take care of: Please fill out all the following paperwork. **(HIPPA** and **Financial Policy you will sign in computer in office)** in addition we would like you to fill out questions below. Thank you & have a great day ☺

NAME: _____ DATE: _____

DENTAL HISTORY

May we ask who referred you to our office _____

Reason for today's visit _____

Former Dentist_____ Date of last dental visit_____ Date of last X-rays_____

Immediate Dental Concerns_____

Long Term Dental Concerns_____

Your Dental Goal_____

	Yes	No		Yes	No
Bad Breath Issues	___	___	Lip/cheek Biting	___	___
Bleeding Gums	___	___	Loose teeth/broken fillings	___	___
Blister on lips or mouth	___	___	Mouth Breathing	___	___
Burning sensation on tongue	___	___	Orthodontic Treatment (Braces)	___	___
Chew on one side of mouth	___	___	Pain around ear	___	___
Prior Periodontal treatment	___	___	Jaw pain or tiredness	___	___
Clicking or popping jaw	___	___	Sensitivity to cold	___	___
Dry mouth	___	___	Sensitivity to heat	___	___
Fingernail biting	___	___	Sensitivity to sweet	___	___
Grinding/Clenching Teeth	___	___	Sensitivity when biting	___	___
			How often do you brush?	_____	
			How often do you floss?	_____	

PATIENT REGISTRATION

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Address: _____ Apt # _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: ○ Female ○ Male Birth date: _____ Social Security # _____

E-mail: _____

Patient is: □ Responsible Party □ Policy Holder

Preferred Pharmacy: _____ Referred By: _____

Responsible or Insured Party: (if different from the patient above)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Apt # _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone _____

Birth date: _____ Social Security # _____

○ **Responsible Party is Policy Holder for Patient** ○ **Primary Policy Holder** ○ **Secondary Policy Holder**

Primary Insurance Information:

Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Insurance ID# _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Secondary Insurance Information:

Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Insurance ID# _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Eaglesoft Medical History Updated 5-2-17(Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics
Other			

Do you use controlled substances?	Yes No	If yes
Other?		If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Hepatitis A	Yes No	Anaphylaxis	Yes No	Drug Addiction	Yes No
Hepatitis B or C	Yes No	Renal Dialysis	Yes No	Anemia	Yes No	Easily Winded	Yes No
Herpes	Yes No	Rheumatic Fever	Yes No	Angina	Yes No	Emphysema	Yes No
High Blood Pressure	Yes No	Rheumatism	Yes No	Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No
High Cholesterol	Yes No	Scarlet Fever	Yes No	Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No
Hives or Rash	Yes No	Shingles	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Bruise Easily	Yes No
Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No	Cancer	Yes No
Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No	Chemotherapy	Yes No
Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No	Chest Pains	Yes No
Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No	Cold Sores/Fever Blisters	Yes No
Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No	Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No
Parathyroid Disease	Yes No	Convulsions	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No	Sleep Apnea	Yes No	Diabetes	Yes No	Excessive Thirst	Yes No
Heart Murmur	Yes No	Heart Trouble/Disease	Yes No				

Have you ever had any serious illness not listed	Yes No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

Sleep Screening Questionnaire

Please answer the questions below to help us assess the possibility of a sleep disorder which may be related to your dental and overall health. There is often a correlation between grinding of the teeth, TMJ disorders, breakdown of the teeth and sleep disorders. Sleep apnea may also increase your risk for many different health conditions including heart attack and stroke. If you are here with your child (under 16), please fill out the lower portion marked "For children only" for your child.

Name:_____ **Height:**_____ **Weight:**_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze
1 = I have a slight chance of dozing
2 = I have a moderate chance of dozing
3 = I have a high chance of dozing

Situation	Chance of Dozing
1. Sitting and reading	____
2. Watching TV	____
3. Sitting inactive in a public place (e.g. a theater or a meeting)	____
4. As a passenger in a car for an hour without a break	____
5. Lying down to rest in the afternoon when circumstances permit	____
6. Sitting and talking to someone	____
7. Sitting quietly after lunch without alcohol	____
8. In a car while stopped for a few minutes in traffic	____
Total Score	____

Have you ever been diagnosed with:	Yes	No
1. Impaired Cognition (i.e. difficulty concentrating or thinking)	☐	☐
2. Mood Disorders/Depression	☐	☐
3. Insomnia	☐	☐
4. Hypertension (high blood pressure)	☐	☐
5. Ischemic Heart Disease (Coronary Artery Disease/Atherosclerosis)	☐	☐
6. History of Stroke	☐	☐
7. Sleep Apnea	☐	☐
If yes: Did you try to use CPAP	☐	☐
8. TMJ problems significant enough to require treatment	☐	☐
9. Gastric Reflux (GERD) or Heartburn	☐	☐

Are you aware of (or have you been told):	Yes	No
1. Snoring on a regular basis	☐	☐
2. Feeling tired or fatigued on a regular basis	☐	☐
3. Clenching or grinding your teeth (bruxism)	☐	☐
4. Having frequent headaches	☐	☐
5. Your neck size being > 17 inches (male) or > 16 inches (female)	☐	☐
6. Anyone in your family having sleep apnea	☐	☐
7. Stopping breathing when sleeping/awakening with a gasp	☐	☐

For children only (filled out by parent or guardian)

Are you aware of your child:	Yes	No
1. Snoring/noisy breathing while sleeping	☐	☐
2. Grinding his or her teeth	☐	☐
3. Wetting the bed	☐	☐
4. Having difficulty in school/learning	☐	☐
5. Being treated for ADD or ADHD	☐	☐
6. Breathing primarily through their mouth	☐	☐
7. Having frequent nightmares/night terrors	☐	☐
8. Having frequent ear aches	☐	☐

Dental Exam Findings:

☐ Evidence of Bruxism ☐ Scalloping of the tongue ☐ Crowded airway
☐ Tori or Bone Loss ☐ Anterior wear ☐ Retrognathia / Class II