NAME _____
LAST FIRST MIDDLE

STREET _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ SOCIAL SECURITY # ___-___-___

SEX: MALE FEMALE STATUS: SINGLE MARRIED WIDOWED DIVORCED

TELEPHONE: (HOME) _____ (WORK / CELL) _____

eMAIL _____ FAX _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? _____

TELEPHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

ADDRESS _____

EMPLOYER _____ OCCUPATION _____

All services are charged to the patient, I recognize that I am responsible for fees for services rendered regardless of insurance coverage. I understand I am responsible to pay actual and reasonable collection charges and/or attorney fees.

SIGNATURE: _____ DATE: _____

PATIENT INFORMATION

BARRY ROZENBERG DDS
1000 BROADWAY
WOODMERE, NY 11598

BARRY ROZENBERG DDS
18 E. 48TH ST
NEW YORK, NY 10017

BARRY ROZENBERG DDS
1000 BROADWAY
WOODMERE NY, 11598

BARRY ROZENBERG DDS
18 E. 48TH STREET
NEW YORK, NY 10017

PATIENT NAME _____
LAST FIRST MIDDLE

PHYSICIANS NAME _____
ADDRESS/PHONE # _____
_____
DATE OF LAST VISIT _____
LIST CURRENT MEDICATIONS: _____
_____

ARE YOU ALLERGIC TO ANY MEDICATIONS OR SUBSTANCES?
PLEASE CIRCLE BELOW
ASPIRIN PENICILLIN CODEINE LATEX RUBBER ACRYLIC
OTHER: _____

DO YOU NEED PREMEDICATION PRIOR TO A DENTAL VISIT? YES NO
IF YES, WHY? _____

HAVE YOU EVER BEEN HOSPITALIZED? YES NO
IF YES, WHY? _____

HAVE YOU EVER HAD A SERIOUS ILLNESS OR MAJOR INJURY? YES NO
IF YES, WHY? _____

DO YOU SMOKE? YES NO HOW MUCH? _____
DO YOU WEAR CONTACT LENSES? YES NO
(*WOMEN*) PLEASE CIRCLE IF APPROPRIATE: TAKING BIRTH CONTROL PILLS
PREGNANT/TRYING TO GET PREGNANT NURSING

PLEASE CIRCLE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

RHEUMATIC FEVER	ASTHMA	ARTIFICIAL JOINT
RHEUMATIC HEART DISEASE	DIABETES	SKIN RASH / HIVES
HEART MURMUR	FREQUENT URINATION	CORTISONE TREATMENT
MITRAL VALVE PROLAPSE	EXCESSIVE THIRST	HIV
PROSTHETIC HEART VALVE	HYPOGLYCEMIA	AIDS
IRREGULAR HEART BEAT	ANEMIA	GLAUCOMA
SHORTNESS OF BREATH	BRUISING	THYROID PROBLEMS
CHRONIC TIREDNESS	CANCER	BLOOD TRANSFUSION
CHEST PAIN / ANGINA	RADIATION THERAPY	CHEMICAL DEPENDENCY
HEART ATTACK	CHEMOTHERAPY	PSYCHIATRIC CARE
HIGH BLOOD PRESSURE	TUMOR OR GROWTH	COLD SORES
HIGH CHOLESTOROL	STOMACH ULCERS	SICKLE CELL DISEASE
STROKE	KIDNEY PROBLEMS	ARTHRITIS
SEIZURES / CONVULSIONS	RENAL DIALYSIS	ALLERGIES (MEDICINES)
FAINTING / DIZZINESS	TUBERCULOSIS	PARKINSONS DISEASE
HEADACHES	PERSISTENT COUGH	DRUG ADDICTION

OTHER MEDICAL ISSUES NOT CIRCLED ABOVE: _____

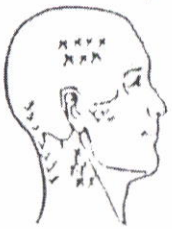
SIGNATURE: _____ DATE: _____

MEDICAL HISTORY

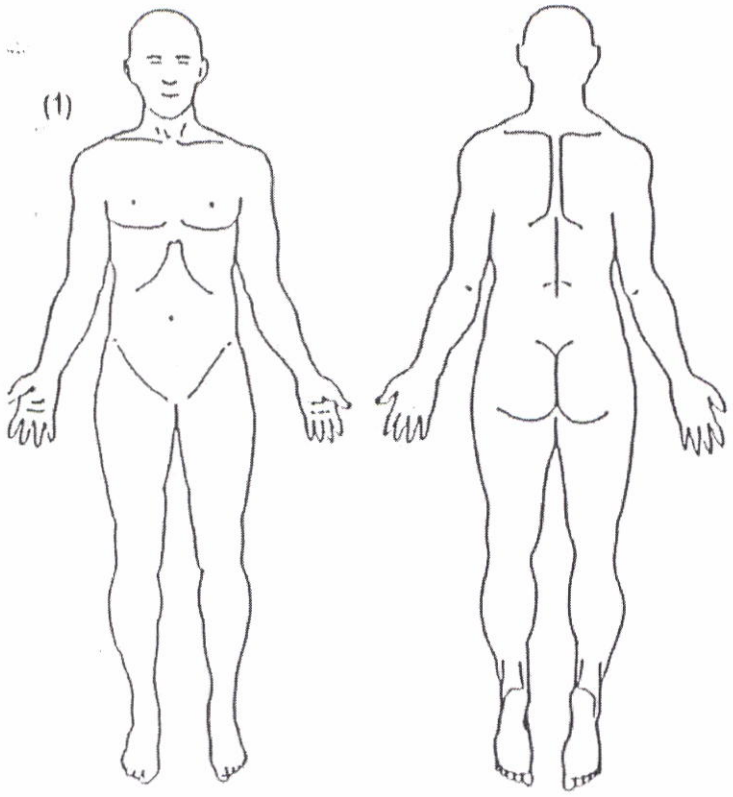
Pain Location Chart

(1) Please draw the location of the areas that are painful; the most painful in **bold x's**, less painful in ✓✓✓.

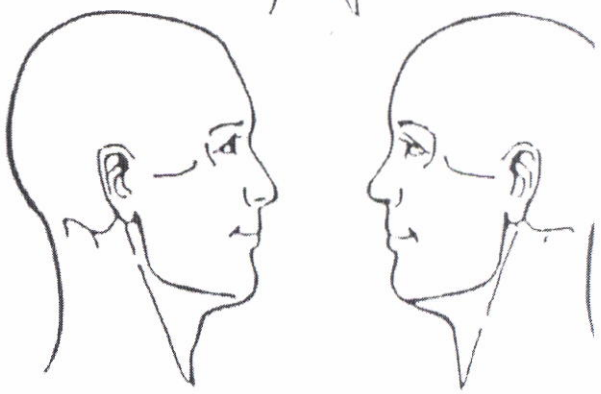
As an example:



(1)



R L



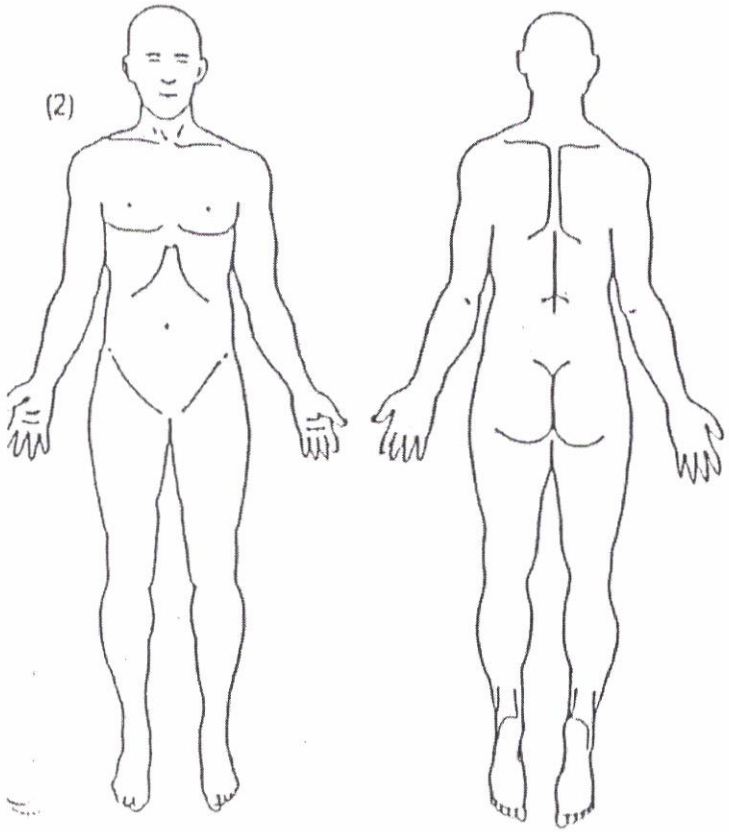
Approximate date of onset of

Most painful areas: _____

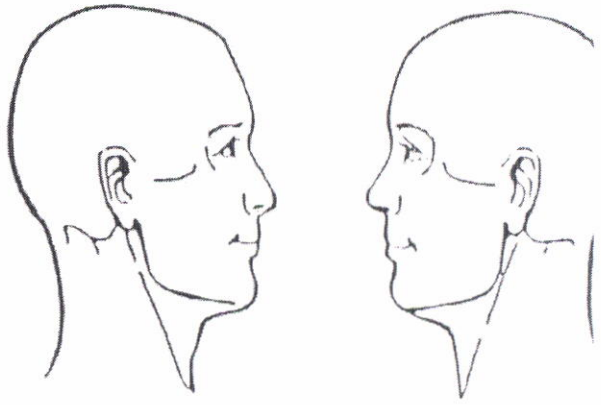
Less painful areas _____

(2) Please mark all areas that are numb with **x's**; that tingle with ✓✓✓; all scars with ++++

(2)



R L



Approximate date of onset of

Numbness: _____

Tingling: _____

Dates of scars: _____

_____

Date: _____ Patient's signature: _____

TMJ QUESTIONNAIRE #2

Name:_____ DATE:_____

If caused by an accident, describe briefly:_____
_____
_____
_____

Family Physician:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone: ( )_____

Family Dentist:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone: ( )_____

On the lines below, please list the doctors you have consulted for your complaint. Briefly describe their diagnosis, treatment and results. Be certain to include medication prescribed for you. Please bring copies of all available reports and x-rays.

Dr._____ Phone:( )_____
Address:_____ State:_____ Zip:_____
Specialty:_____ Date seen:_____
Diagnosis and treatment:_____
_____
_____

Dr._____ Phone:( )_____
Address:_____ State:_____ Zip:_____
Specialty:_____ Date seen:_____
Diagnosis and treatment:_____
_____
_____

Dr._____ Phone:( )_____
Address:_____ State:_____ Zip:_____
Specialty:_____ Date seen:_____
Diagnosis and treatment:_____
_____
_____

Dr._____ Phone:( )_____
Address:_____ State:_____ Zip:_____
Specialty:_____ Date seen:_____
Diagnosis and treatment:_____
_____
_____

Briefly describe your problem:_____
_____
_____

What do you feel is the cause?_____
_____
_____

What do you hope to gain from treatment of your problem?_____
_____
_____
_____

TMJ AND OROFACIAL PAIN QUESTIONNAIRE #1

NAME:_____ DATE:_____

Do you suffer from any of the following symptoms? [Please CIRCLE Number]

1. Frequent headaches – including migraine, tension & sinus headaches
2. Dizziness
3. Nausea
4. Earaches
5. Loss of hearing (L) (R)
6. Ringing, buzzing or other sounds in the ears
7. A feeling of clogged, fullness or stuffiness in the sinuses or ears
8. Difficulty in opening or closing your mouth (L) (R)
9. Clicking (or other sounds) from your jaw joint (now or previously)
10. Pain in the jaw joint or any other joints
11. Inability to open mouth fully
12. Pain in facial muscles
13. Pain in the upper and/or lower teeth
14. Pain in or behind eye(s)
15. Blurred vision
16. Backaches
17. Neckaches
18. Numbness in fingertips
19. Are you easily fatigued at the end of the day?
20. Have you had whiplash or trauma?
21. Pain upon chewing, swallowing, yawning, speaking?
22. Are jaw muscles fatigued?
23. Have you had extensive dental treatment
24. Have you had orthodontics? When?
25. Do your eyes tear for no apparent reason?
26. Do you (or did you) have facial swelling?
27. Oral habits:
    - Gum chewing
    - Nail biting
    - Pencil chewing
    - Play a musical instrument
    - Clench teeth together
        a. During daytime
        b. During sleep
        c. Upon awakening
28. Is there an activity that this condition prevents you from doing?
29. Pain other than head, face or jaws
    - Upper back (L) (R)
    - Middle back (L) (R)
    - Lower back (L) (R)
    - Shoulder blade (L) (R)
    - Neck (L) (R)
    - Shoulder (L) (R)
    - Arm (L) (R)
    - Finger (L) (R)
    - Chest (L) (R)
    - Hip (L) (R)
30. Are you married?
31. Do you have children?
32. Do you work?
33. Satisfied with job?
34. Are you depressed or nervous?
35. Do you sleep well?
36. Do you eat properly?
37. Have you had a severe emotional upset?
38. Have you had psychiatric treatment?
39. Have you ever had biofeedback?

I hereby authorize and request you to release to my referring and/or attending physicians the complete history and records in your possession concerning my treatment. To the best of my knowledge, all of the preceding answers are true and correct.

_____

Patient's Signature

BARRY ROZENBERG, DDS

OROFACIAL PAIN
TMJ DISORDERS

SLEEP APNEA
SNORING APPLIANCES

APPOINTMENT POLICY

We are committed to providing you with the highest quality care in the most efficient manner possible.

To ensure that you receive the highest quality treatment we schedule only one patient at a time.

When a patient has a scheduled appointment, there is much preparation that takes place well in advance of that time slot.

Our doctor wants to be available for your needs and the needs of all our patients.

When a patient does not show up for a scheduled appointment or does not call to cancel in advance, another patient loses the opportunity to be seen and, of course, the office loses production for that appointment slot.

Therefore any changes made within 24 hour of your appointment will incur a $100 fee.

Thank you for your understanding and cooperation as we institute this policy.

_____
Print Name of Patient / Guardian

_____ _____
Signature Date

1000 Broadway
Woodmere, NY 11598

516-791-2200

18 E. 48th Street
ew York, NY 10017

877-863-1222

www.tmj-painaway.com

NOTICE OF PRIVACY PRACTICES

Protecting Your Confidential Health Information is Important to Us

Notice of Privacy Practices

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.

Our Promise!

Dear Patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA - Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed? Why a privacy policy now? Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

How your HEALTH INFORMATION may be used

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgment

Patient Name(s):_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

_____

Patient Signature

Date _____/_____/_____

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosure of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health informatic usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notic of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practice we will be sure all of our patients receive a copy of the revised Notic

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concern you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.