



Leonid Portugeys DDS

2523 Ocean Avenue, Brooklyn, NY 11229 - (718)934-2600 www.drportugeysdds.com

Get Acquainted Questionnaire

For us to better serve you, please fill out the following information **COMPLETELY**

Name: _____
(first) (middle) (last) (preferred)

Address: _____
(number & street) (city) (state) (zip code)

Social Security #: _____ Date of Birth: _____ Home

Telephone: _____ Business Telephone: _____

Email: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Whom
may we thank for referring you? _____

Are you married? Yes ___ No ___ Spouse's name: _____

Emergency Contact

Name: _____ Phone Number: _____

Relationship to Patient: _____

For Patients with Dental Insurance

Primary Insurance

Insurance Carrier: _____ Group #: _____

Name of Insured: _____ Relationship to Patient: _____ SS#(or
ID#) _____ DOB: _____

(if different from above)

Secondary Insurance

Insurance Carrier: _____ Group #: _____

Name of Insured: _____ Relationship to Patient: _____

SS#(or ID#) _____ DOB: _____

If patient is a student – Name of school: _____

I hereby authorize Dr Leonid Portugeys to release to
_____ or its representative, and information including the diagnosis and the
(Name of Insurance Company)
records of any treatment or examination rendered to me during the period of such Dental care. I also authorize and
request your company pay directly to Dr Leonid Portugeys the amount due to me in my pending claim for dental
treatment or services, by reason of such treatment or services rendered.

Signature of Insured: _____ Date: _____

MEDICAL HISTORY

Are you currently under the care of a physician? No ____ Yes ____ Please explain _____

Are you taking any prescription/over the counter drugs? No ____ Yes ____ Please list each one _____

For Women: Do you take any form of birth control? No ____ Yes ____ Which kind? _____

Are you pregnant? No ____ Yes ____ How many weeks? _____

Are you nursing? No ____ Yes ____

Do you have or have you ever had any of the following diseases or medical problems? **If NO, please circle NO**

- | | | |
|--------------------------|------------------------------|---------------------------|
| Y N Heart Attack | Y N Stroke | Y N Cancer |
| Y N Chemotherapy | Y N Heart Murmur | Y N Heart Defect |
| Y N Rheumatic Fever | Y N HIV | Y N AIDS |
| Y N Heart Surgery | Y N Crohn's Disease | Y N Hepatitis |
| Y N Pacemaker | Y N Shingles | Y N Mitral Valve Prolapse |
| Y N Kidney Problems | Y N Artificial Bones, Joints | Y N Artificial Valves |
| Y N Sinus Problems | Y N High Blood Pressure | Y N Low Blood Pressure |
| Y N Fever Blisters | Y N Blood Transfusion | Y N Migraines |
| Y N Psychiatric Problems | Y N Epilepsy | Y N Seizures |
| Y N Fainting Spells | Y N Diabetes | Y N Tuberculosis (TB) |
| Y N Venereal Disease | Y N Hemophilia | Y N Abnormal Bleeding |
| Y N Ulcers | Y N Colitis | Y N Anemia |
| Y N Radiation Treatment | Y N Asthma | Y N Arthritis |
| Y N Difficulty Breathing | Y N Hospitalized | |
| Y N Glaucoma | Y N Emphysema | |

Please list any other serious medical condition(s) that you may have ever had: _____

Are you allergic to any of the following drugs? **If No, please circle NO**

- | | | |
|------------------|------------------------|-----------------|
| Y N Penicillin | Y N Tetracycline | Y N Latex |
| Y N Aspirin | Y N Codeine | Y N Ibuprofen |
| Y N Erythromycin | Y N Dental Anesthetics | Y N Sulfa Drugs |

Please list any other drugs that you are allergic to:

DENTAL HISTORY

Have you ever had a serious problem associated with any previous dental work? No ____ Yes ____

Have you ever experienced pain/discomfort in your jaw (TMJ/TMD)? No ____ Yes ____

Do you like your smile? No ____ Yes ____

Do your gums ever bleed? No ____ Yes ____

How many times a week do you floss? _____

How many times a day do you brush? _____

I affirm that the information that I have given today is correct to the best of my knowledge. I understand that Dr Leonid Portugeys safeguards my information in accordance with the HIPPA guidelines. I also understand that it's my responsibility to inform the office of any changes in my medical history.

I authorize, with informed consent Dr Leonid Portugeys to perform any necessary dental services to help maintain my oral health, including diagnosis and treatment.

Signature _____

Date _____

FINANCIAL POLICY

ENDODONTIC CARE NY

DR. LEONID PORTUGEYS, D.D.S

2523 Ocean Avenue, Brooklyn, NY. 11229

Dr. Leonid Portugeys strives to be punctual, therefore we ask that our patients keep their appointments and arrive on time. If a patient must cancel an appointment, we require at least 24-hour notice.

Dr. Portugeys will make every effort possible to assist our patients with their insurance, however please keep in mind that dental insurance is a contract between the insurance and the patient, not the provider. It is up to the patient to fully understand his/her benefits to ensure the appropriate disbursement of benefits under the terms of each individual plan.

As a courtesy to our patients, Dr. Portugeys provides a treatment plan of which includes an estimate of the recommended treatment, the expected coverage from the dental coverage as well as the patient's copayment respectively. Benefits quoted to you are only an estimate provided by the insurance company and not a guarantee of payment or eligibility at the time the services are performed. Dr. Portugeys will submit claims and accept the assignment of benefits from the insurance company on behalf of the patient provided the patient pays their co-payment for each visit, due at the time of treatment, unless prior arrangements have been made.

If the claim is not paid by the insurance company within 30 days, the balance becomes the patient's responsibility and is due immediately. Any balances that remain unpaid after 90 days will be referred to a third party for collections.

A misunderstanding can be an obstacle in establishing a successful relationship. If at any time you have a question regarding treatment plan, fee or service, please discuss it with us promptly and openly.

I, the undersigned have read and understood the above and I consent to all the terms and conditions set forth in this agreement.

Signature **X** _____ Date _____

PATIENT HIPAA CONSENT FORM

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

ENDODONTIC CARE NY, P.C.

DR. LEONID PORTUGEYS, DDS

In accordance with federal and state law, we must obtain your written authorization before we may use or disclose your protected health information for the purposes described below. Please read the information below carefully before signing this form. **All fields must be completed.**

Patient Name:	Date of Birth:	Sex:
Patient Address:	Phone Number:	

I, or my personal representative, hereby authorize Endodontic Care NY, P.C. to use or disclose protected health information regarding my care and treatment. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers
- The day- to- day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signature: X _____ Date: ___/___/___

Print Patient Name: _____

Relationship to Patient: _____

HIPAA email consent

VERY IMPORTANT! PLEASE READ!

- HIPAA stands for the Health Insurance Portability and Accountability Act
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored on our computers is encrypted
- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email
- When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA
- The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website
- <http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf>
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email

OPTION 1 – ALLOW UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to the Endodontic Care of NY to send me personal health information via unencrypted email

Signature **Date** **Printed name** **Please print email address**
(parent or guardian if patient is a minor)

OPTION 2 – DO NOT ALLOW UNENCRYPTED EMAIL

I do not wish to receive personal health information via email

Signature **Date** **Printed name (parent or guardian if patient is a minor)**

Please bring completed form to your visit

Endodontic Care NY, PC

*2523 Ocean Ave
Brooklyn, NY 11229
(718)934-2600*

Cancellations / No Show Policies

Cancellation / No Show Advance Notice Requirements:

In order to provide the most efficient scheduling to our patients, we need to keep appointment cancellation and “no show” activity to a minimum. In order to do this, we are implementing cancellation and “no-show” fees that will be charged to the patient if office visits and/or procedures are cancelled without proper advance notice, or if the patient does not show up for a scheduled office visit and/or procedure.

Cancellation Notice Requirements:

Office Visit: 24 hours advance notice.

Failure to provide the required advance notice will result in a **cancellation fee of \$100.00**

Procedure Visits: 24 hours advance notice

Failure to provide the required advance notice will result in a **cancellation fee of \$100.00.**

As a courtesy, we make every effort to remind patients of their office visit by telephone 1 business day before the appointment date. These are calls to confirm the appointment as well as calls to remind the patient of their appointment. **It is your responsibility to provide us with the appropriate advance notice if you need to cancel an office visit.**

Cancellations can be made at ANY time by calling **718-934-2600.**

Thank you for your cooperation in helping us to provide quick and efficient care to all of our patients.

Signature of Patient: _____ Date: _____