Dr. Glenn W. Horrigan

PATIENT INFORMATION

Today's date: _____

First Name: _____ MI: _____ Last Name: _____ Nickname: _____

Sex: ❑M ❑F Date of Birth: _____ Age: _____ SS#: _____ E-mail: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Bus. Phone: _____ Cell Phone: _____

Employer: _____ Referred By: _____

Physician: _____ Physician Phone: _____

Driver's License #: _____ Nearest relative not living with you: _____ Phone: _____

Have you ever been a patient of our practice? ❑Yes ❑No

Method of Payment: ❑Cash ❑Check ❑Credit Card Pharmacy: _____

Do you belong to a PPO or HMO: ❑Yes ❑No Pharmacy Phone: _____

PERSONAL INFORMATION

Marital Status: ❑Married ❑Divorced ❑Legally Separated ❑Widow ❑Single

Employment: ❑NA ❑Full-Time ❑Part-Time ❑Retired

Student: ❑NA ❑Full-Time ❑Part-Time School Name/Location: _____

RESPONSIBLE PARTY (if self, skip to the next section)

❑Self ❑Spouse ❑Father ❑Mother ❑Other Home Phone: _____

Name: _____ SS#: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Phone: _____

SECONDARY RESPONSIBLE PARTY (if different from above)

❑Spouse ❑Father ❑Mother ❑Other Home Phone: _____

Name: _____ SS#: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Phone: _____

PRIMARY DENTAL INSURANCE COMPANY

Employer: _____

Business Address: _____

Phone: _____ Plan: _____

Insurance Company: _____

Group Name: _____

Group #: _____

Identification #: _____

Primary Insured: _____

Relationship to Primary Insured: _____

SECONDARY DENTAL INSURANCE COMPANY

Employer: _____

Business Address: _____

Phone: _____ Plan: _____

Insurance Company: _____

Group Name: _____

Group #: _____

Identification #: _____

Primary Insured: _____

Relationship to Primary Insured: _____

DENTAL INFORMATION

Reason for today's visit: ❑Emergency ❑Exam ❑Schedule Procedure ❑Consultation

Are you in any pain? ❑Yes ❑No If yes, how long have you been in pain? _____

Please indicate if you have any of the following problems by checking off the corresponding box:

❑Discomfort, Clicking or Jaw Popping ❑Lost or Broken Filling(s) ❑Stained Teeth

❑Red, Bleeding or Swollen Gums ❑Teeth Grinding ❑Locking Jaw

❑Sensitive Tooth or Gums ❑Ringing Ears ❑Bad Breath

❑Blisters/Sores in or Around the Mouth ❑Broken/Chipped Tooth ❑Other (please explain below)

Other: _____

Have you ever required pre-medication? ❑Yes ❑No ❑Not Sure

Previous dentist: _____ Phone: _____

Last dental exam: _____ Last dental x-rays: _____

How many times per day do you brush? _____ How many times per week do you floss? _____

What type of toothbrush bristles do you use? ❑Soft ❑Medium ❑Hard

MEDICAL HISTORY

Are you taking any of the following medications? ❑ Nerve Pills ❑ Pain Killers ❑ Muscle Relaxer
❑ Stimulants ❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other (list)
Other medications: _____

Do you have or have had any of the following diseases, medical conditions or procedures? Please check proper box for **each** item.

Y N		Y N		Y N		Y N	
❑❑	Heart Attack/Stroke	❑❑	Thyroid Problems	❑❑	Cancer/Tumors	❑❑	Cosmetic Surgery
❑❑	Heart Surgery/Pacemaker	❑❑	Kidney Problems	❑❑	Shingles	❑❑	X-ray or Cobalt Treatment
❑❑	Heart Murmur	❑❑	Liver Problems	❑❑	Hepatitis	❑❑	Chemotherapy
❑❑	Rheumatic Fever	❑❑	Respiratory Problems	❑❑	HIV/AIDS/ARC	❑❑	Asthma
❑❑	Mitral Valve Prolapse	❑❑	Sinus Problems	❑❑	Arthritis/Rheumatism	❑❑	Difficulty Breathing
❑❑	Artificial Valves	❑❑	Stomach Problems/Ulcers	❑❑	Artificial Bones/Joints	❑❑	Diabetes/Hypoglycemia
❑❑	Heart Disease	❑❑	Psychiatric Problems	❑❑	Emphysema	❑❑	Leukemia
❑❑	Congenital Heart Defect	❑❑	Venereal Disease	❑❑	Fainting/Seizures/Epilepsy	❑❑	Anemia
❑❑	Chest Pains	❑❑	Alcohol / Drug Abuse	❑❑	Severe/Frequent Headache	❑❑	High/Low Blood Pressure
❑❑	Scarlet Fever	❑❑	Tuberculosis TB	❑❑	Frequent Neck Pain	❑❑	Bleeding Problems
❑❑	Nervousness	❑❑	Jaw Problems TMJ/TMD	❑❑	Back Problems	❑❑	Glaucoma

Are you currently or have you taken in the past (either orally or through IV) any of the following drugs:

Y N		Y N	
❑❑	Actonel (Risedronate) for Osteoporosis	❑❑	Aredia (Pamidronate) for Cancer, Pagets
❑❑	Bonefos (Clondronate) for Cancer	❑❑	Boniva (ibandronate) Osteoporosis
❑❑	Didronel(Etidronate) Pagets	❑❑	Fosamax (Alendronate) Osteoporosis, Pagets
❑❑	Ostac (Clondronate) Cancer	❑❑	Skelid (Tiludronate) Pagets's
❑❑	Zometa (Zoledronic Acid) Osteoporosis, Cancer		

MEDICAL HISTORY (continued)

List any other medical condition(s) you have or have had: _____

Are you allergic to the following? ❑ Latex ❑ Tetracycline ❑ Aspirin ❑ Dental Anesthetics
❑ Penicillin/Amoxicillin ❑ Not Sure ❑ Other (list)
Other Allergies: _____

Do you smoke? ❑Yes ❑No How many per day? _____ How long have you smoked? _____
Other tobacco products? ❑Yes ❑No What type of tobacco? _____ How often? _____ How long? _____
Please rate your general health 1-10: _____ Do you wear contact lenses? ❑Yes ❑No
Have you ever taken the drug Phen-fen or Redux ❑Yes ❑No
For women only:
Are you taking Birth Control pills? ❑Yes ❑No
How many children have you birthed? _____
Are you currently pregnant? ❑Yes ❑No If yes, how many months are you? _____
Are you nursing? ❑Yes ❑No

Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with our office. If the account is not paid in full of the date of services and no financial arrangements have been made, the undersigned party hereby agrees to be liable, in addition to the amount due, for any and all costs, legal fees, disbursements, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. This agreement is of an ongoing nature, and will continue to govern all present and future dental services rendered by Dr. Glenn W. Horrigan.

Signature: _____ Date: _____
❑Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE
(Office Use Only)

Initials Date

Comments

Initials Date

Comments

Initials Date

Comments

Print Form **Submit Form**

Glenn W. Horrigan, DDS

2553 West Church Street
Eden, New York 14057

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Office Cancellation Policy

We understand there are times when appointments cannot be kept. We ask that you call to cancel any appointments that you are unable to keep so that we may use your allotted time for other patients. There will be a minimum charge of $30.00 for all appointments cancelled with less than 24 hours notice. Cancellations on the day of the appointment will incur a $35.00 charge. Broken appointments (no shows) will be charged $40.00. We regret that we need to implement this policy, but the frequency of cancellations and no shows has increased significantly. We respect your time, please respect ours.

Thank you for your cooperation in this matter. We look forward to a long and healthy relationship.

I understand the above information and agree to abide by the above cancellation policy. This policy applies to all parties in my account for which I am legally responsible. I realize that this agreement is of an ongoing nature, and will continue to govern all present and future dental services rendered by Dr Glenn W. Horrigan.

Print Name _____

Signature_____ Date_____

Glenn W. Horrigan, DDS

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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/2003), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.75 for each page, $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: **Glenn W. Horrigan, DDS**

Telephone: **716-992-4215** Fax: **716-992-4993**

E-mail: **docglenn@roadrunner.com**

Address: **2553 West Church Street Eden, New York 14057**