Joseph R. Giovannone, DDS
Michael J. Fanelli, DDS
Eric Giovannone, DMD
315.797.2555
www.dentalarts.org

We are delighted to welcome you to our practice and are pleased that you chose us to serve your dental needs. Enclosed is our "New Patient Package". It includes the following:

1. Directions to our office
2. A federally required HIPAA privacy notice and signature form.
3. A copy of our financial policy.
4. A patient information/medical and dental health history questionnaire.

Our modern facility is fully equipped and computerized, allowing us to better serve your dental treatment needs … to aid in financial matters, to promptly process insurance claims and to have reliable and innovative ways for you and our office to communicate.

If you are ever unable to make an appointment you have scheduled with us, please notify us at least 24 hours in advance. We would be glad to reschedule the appointment at a more convenient time. We look forward to seeing you and to serving your needs.

Thank you in advance for your cooperation. Yours in better health,

All of us at The Dental Arts Office

Referral Information

How did you hear about our office? Check all that apply. *If a person referred you, please write their name on the line.

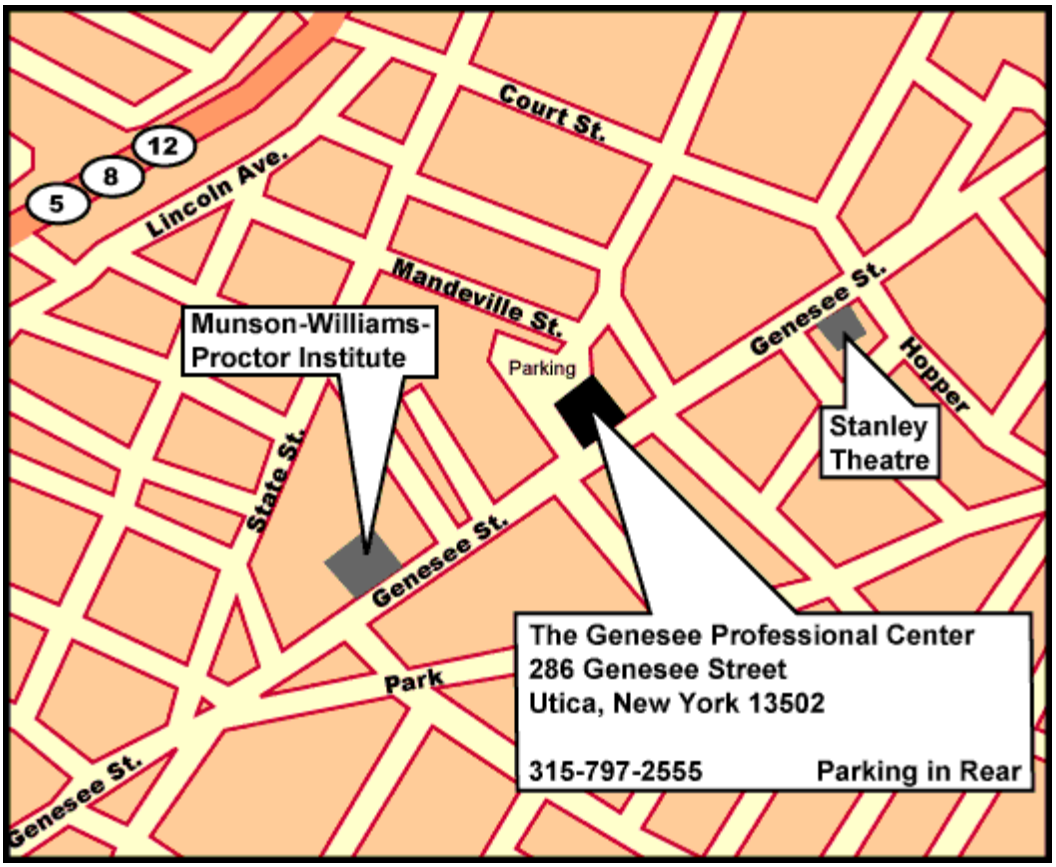
____ www.dentalarts.org ____ Facebook ____ Yellow Pages ____ TV

____ Radio ____ Billboard ____ Referring Dentist or Physician

____ Friend/Family _____

Directions to the Dental Arts

The Dental Arts is conveniently located on the 1st floor of the Genesee Professional Center, 286 Genesee Street, downtown Utica. Our office is fully handicap-wheelchair accessible. Enter through the rear parking lot carport to the ground floor lobby and take the elevator up to the 1st floor, where our office is straight ahead. From the Genesee Street entrance, go up the half flight of stairs straight ahead to our office. The rear parking lot has 3 access points, 2 off Genesee Street from either side of The Genesee Professional Center and 1 on the corner of Cornelius Street and Mandeville Street. Call our staff for best directions when entering Utica from outside the area.



Joseph Giovannone DDS / Michael Fanelli DDS / Eric Giovannone DMD

Hipaa Regulations

These are new federal regulations that require us to notify you that your health, dental and other information may be used for… treatment, payment and general operations.
We must make the effort to secure your acknowledgement of receipt of this notice.
As usual, you always have access to this information with few exceptions.
This form, "Notice of Privacy Practices", presents the information that the federal law requires us to make available to our patients regarding our privacy practices.

New regulations: Effective April, 14, 2003.

We must provide this Notice to each patient. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

From The Dental Arts Office

"Privacy Statement" … Our commitment to you

- We will safeguard with strict confidentiality any personal health information that you share with us
- Our employees are trained in privacy practices
- We do not provide patient list for any vendors or unaffiliated third parties

We Do:

- Send information and x-rays of your condition to your dental insurance (i.e. for a fixed bridge prosthesis, filling, crown) including your name and address
- Review your pertinent health information with another physician, dentist or specialist that could be involved with your treatment either written or orally
- Intra-office review of information between staff members

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

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

_____
Print Name (Relationship if not patient)

_____
Signature

_____
Date

_____ I refuse to sign this Acknowledgement

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) _____

DENTAL ARTS OFFICE PAYMENT POLICY

Dental Arts is a fee for service practice. Payment is due at the time of service. Insurance claims will be processed for your convenience, and monies received from your dental insurance can be applied to your account as listed below:

PATIENTS WITHOUT DENTAL INSURANCE:

Payment is due at the time services are started. Acceptable forms of payment are described below.

PATIENTS WITH DENTAL INSURANCE:

Claims will be submitted to your insurance provider for your convenience. Our system allows us to ESTIMATE the portion of your services they may cover.

**For insurance companies that make our office assignable (they send payment directly to us), patients pay the uncovered portion of their treatment at the time of service by one of the payment forms below.

**For insurance companies that make payment directly to the patient, services are to be paid in full, and the patient will be reimbursed directly from their dental insurance provider.

**Patients with dual insurance should speak directly to a team member for a thorough explanation of their coverage, as these situations often require more detailed handling.

**Please note, any balance more than 30 days old is expected to be paid in full regardless of insurance status.

ACCEPTED PAYMENT FORMS:
***CASH**
***CHECK**
***CREDIT** (MasterCard, Visa, Discover, American Express)
***CARE CREDIT** (please visit Carecredit.com, or ask a team member for help/brochures)

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Signature Date

Here at Dental Arts, we pride ourselves on providing our patients with the best dental care we possibly can. By completing comprehensive dental examinations, collecting proper diagnostic information, and taking time to educate our patients about the treatment options available to them, we can achieve excellent results in restoring our clients to ideal oral health and function. In doing this, we are also sensitive to the fact that while the cost of treatments has risen, dental benefits have not changed proportionately. To better assist our patients in reaching their dental goals, we have updated our payment policy to provide options that accommodate a wider range of individual needs.

The Dental Arts Office

www.dentalarts.org
Genesee Professional Bldg / 286 Genesee St Utica, NY 13502
Email: staff@dentalarts.org
Phone: 315-797-2555

Guarantor Information (Person Responsible for Payment)

Name: _____ DOB: _____/_____/_____ SS#: _____

Address:_____ Home # _____
_____ Work # _____
_____ Employer: _____

Patient Information

Name: _____ **DOB:** ____/____/____ **SS#:** _____

Title: Dr / Mr / Ms / Mrs / etc **Family Status:** Married / Single / Child / Other **Gender:** M / F

Address: _____ **Home:** _____
_____ **Mobile:** _____
_____ **Work:** _____ **Ext** _____

Email: _____ **Best time to call**: _____

The patient is my: ___ Self ___ Spouse ___ Child ___ Parent ___ Other: _____

Emergency Contact

Name: _____ **Relationship:** _____ _____
Phone # _____

Primary Dental Insurance Information

Name of Policy Holder: _____ **DOB:** _____
Insurance Company: _____ **Phone #:** _____
Address: _____ **ID #:** _____
_____ **Group #:** _____
Employers Name: _____ **Relationship to patient:** _____

Secondary Dental Insurance Information

Name of Policy Holder: _____ **DOB:** _____
Insurance Company: _____ **Phone #:** _____
Address: _____ **ID #:** _____
_____ **Group #:** _____
Employers Name: _____ **Relationship to patient:** _____

Main reason for your dental visit today: _____

Approximate date of last visit to the dentist, their name and the reason for that visit: _____
_____

I may have had the following x-rays taken recently (Check all that apply)
_____ Full Mouth Series ____ Panorex ____ Bitewings only

Please tell me about your dental problems at this time: _____

Patient Medical and Dental History Information

Place a check next to any conditions you have now or have had in the past:

___ *Pre-med – Amox	___ *Pre-med – Clind	___ *Pre-Med – Other	___ Allergies
___ Allergy – Aspirin	___ Allergy – Codeine	___ Allergy – Erythromycin	___ Allergy – Hay Fever
___ Allergy – Latex	___ Allergy – Other	___ Allergy – Penicillin	___ Allergy – Sulfa
___ Anemia	___ Arthritis	___ Artificial Joints	___ Asthma
___ Blood Disease	___ Blood Thinner	___ Cancer	___ Diabetes
___ Dizziness	___ Down Syndrome	___ Epilepsy	___ Epinephrine Sensitivity
___ Excessive Bleeding	___ Fainting	___ Glaucoma	___ Head Injuries
___ Heart Disease	___ Heart Murmur	___ Hepatitis	___ High Blood Pressure
___ High Cholesterol	___ HIV	___ Jaundice	___ Kidney Disease
___ Liver Disease	___ Mental Disorders	___ Missing Type	___ Nervous Disorders
___ No Allergies	___ Pacemaker	___ Pregnancy	___ Radiation Treatment
___ Respiratory Problems	___ Rheumatic Fever	___ Rheumatism	___ Sinus Problems
___ Stomach Problems	___ Stroke	___ Tuberculosis	___ Tumors
___ Ulcers	___ Venereal Disease	___ X other – list below	

List any other medical Conditions here, including anything you are allergic to or cannot take, that is not listed above: _____
_____

Name your Primary Care Physician: _____ **Last Visit Date:** _____
Name any specialists you see: _____ **Condition Treated for**: _____

Please tell us of any hospitalizations or surgical procedures you have had in the past 3 years: _____
_____
_____

List of Medications that you take (If you have a long list, please give it to the front desk and they will make a copy to put into your chart) _____
_____
_____

I have had the following administered for dental treatment (Check all that apply)
___ Local anesthetic "shots" ___ Nitrous Oxide Gas ___ Anti-anxiety medication

Please tell us about any problems that you may have had when receiving dental treatment or with medications used by a dentist: _____
_____
_____

___ I wear removable dentures/partials. If so, are you happy with them? ____ Yes ___ No

___ I have had 1 or more dental implants placed in my mouth.

___ Are you concerned about the shape, shade or color of any of your teeth? ___ Yes ___ No

Check any of the following forms of tobacco you use: ___ cigarettes ___cigars ___ pipe ___ chewing ___ snuff

Do you wish to discuss treatment options that can improve your smile? __ Yes __ No ___ Maybe, tell me options

I have provided accurate and complete information
Signature: _____ Date: _____