N. Disassa		Information		Date:
Name Please:	t Last	MI	(Preferred Name)	
Gender: Family St	atus: SSN#:			rth:
Home:	Work:	Mobile:		
E-Mail:	A Preferred M	eans to Correspo	ond?	
Address:			Apartment #	
Succi				
City		State	Zip	Code
Date of Last Dental Visit:	Reason for Toda	y/Upcoming Visit:_		
Please check all those that ap AIDS/HIV	☐ Excessive Bleeding	□ Pacemak	er	☐ Tumors
Allergies	☐ Fainting	□ Pregnanc		□ Ulcers
Alleigies	□ Glaucoma			☐ Codeine Allergy
Anemia	☐ Hay Fever		ric Treatment	☐ Latex Allergy
Arthritis	☐ Head Injuries	the state of the s	n Treatment	☐ Penicillin Allergy
Artificial Joints/Knee/Hip	_ fread injuries			
Replacement	☐ Heart Disease	□ Respirato	ory Problems	□ Smoking
Asthma	☐ Heart Murmur	□ Rheumat		□ Osteoporosis
Blood Disease	☐ Hepatitis	□ Rheumat		☐ OTHER: please lis
Cancer	☐ High Blood Pressure	☐ Sinus Pro		
Diabetes	☐ Jaw Joint Problems	□ Stomach	Problems	
Dizziness	☐ Kidney Disease	□ Stroke		
Epilepsy	☐ Liver Disease	☐ Tubercul	losis	
	en asked to take an antibioti			
f yes, please explain:	7	C		
	mitted to a hospital or need	ed emergency ca	are during the pa	st two years?
☐ Yes ☐ No	initied to a nospital of need	ed emergency ec	ne during the pa	st two years.
If yes, please explain:				
 Are you now under 	er the care of a physician?	☐ Yes ☐ No		
 Name of Physician 	n:	Phone:		
	medications you may be ta			
	health problems that need for	THE RESERVE AND ADMINISTRATION AND ADMINISTRATION OF THE RESERVE AND ADMIN		0
If yes, please explain:	neutri problems that heed it	artifici Cidifficatio	on. Lites Lite	
i jes, piedse explain.				
	dge, all of the preceding an ge in my health, I will infor	m Tracey or Dr		
if I should have any chang		John		
Signature of patient, parent	or quardian	Date:		

The following is for: the patient's Name:	spouse the	person responsible	e for payment	
☐ Male ☐ Female SSN #: Date of F	Birth:	Married Single Home:		
Work: Mobile: Address:		Best time to call:		
				Apartment
City		Star	e	Zip Code
The following is for: □ the patient □ the Employer Name:	person responsib	ent Information le for payment Occupation:	on	
Address:Street		City, Stat	e Zip	p Code
	Insuran	ce Information	ı	
Name of Insured:		Is the	Insured a natient	? □ Yes □ No
Last	First	MI		
nsured's Birth Date: nsured's Address:	ID#:		Group#:	
nsured's Employer Name: Address:	City	Stat	e	Zip Code
Patient's relationship to insured: Self	☐ Spouse ☐ Ch	ild □ Other		
	□ Spouse □ Ch	ild 🗆 Other		
The undersigned hereby authorizes the doctor to take x-rai iagnosis of the patient's dental needs.	Consent a	nd Office Police graphs, or any other diagn	ostic aids deemed approp	
The undersigned hereby authorizes the doctor to take x-radiagnosis of the patient's dental needs. The undersigned hereby authorizes the doctor to use photon anonymity is protected. The undersigned hereby authorizes the doctor to use photon anonymity is protected.	Consent a sys, study models, photographs for clinical informarrangements must be marrangements must be marrangements.	nd Office Police graphs, or any other diagnormation usage for study cleade in advance. The practi	ostic aids deemed appropulation of lecture or patient conceeds the depends upon reimburgers.	onsultation information as long as priva
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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.

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 April 9, 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 nealth 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, \$15.00per 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:	Tracey Sanz	
Telephone:	516-766-6767 Fax 516-766-6787 Email: Not Available	
E-mail:	Address: 77 North Centre Avenue	
Address:	Ste. 301 Rockville Centre, NY 11570	

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Joseph P. Fusco, DDS, MAGE	Jose	ph	P.	Fusco,	DDS,	MAGE
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

1,	, have received a copy of the
	s Notice of Privacy Practices.
Pi	ease Print Name
Sig	gnature
Da	te
	For Office Use Only
We atte	empted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but eledgement 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)
_	

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