SHERESE LEONARD, D.D.S., P.C.
83 CROSSWAY DRIVE
DEER PARK, NEW YORK 11729
(631) 667-7778

PERSONAL INFORMATION

NAME_________________________ D.O.B.__________ S.S.#______________

HOME ADDRESS____

CITY__________________________ STATE____________ ZIP___________

HOME PHONE____________________ WORK PHONE__________________

OTHER PHONE____

OCCUPATION____________________ EMPLOYER_____________________

WORK ADDRESS____

PERSON FINANCIALLY RESPONSIBLE_____________________________

DENTAL INSURANCE ________________________ GROUP #___________

MAILING ADDRESS____

SPOUSE NAME____________________ EMPLOYER_____________________

S.S.#___________________

HOW DID YOU HEAR ABOUT OUR OFFICE?______________________

MEDICAL HISTORY

PHYSICIAN______________________ ADDRESS______________________

ARE YOU IN GOOD HEALTH?__________ IF NO, EXPLAIN___________

HAVE YOU BEEN HOSPITALIZED IN THE PAST 3 YEARS?__________

IF SO, FOR WHAT?____

DO YOU SMOKE?___________ IF SO, HOW MUCH?_________________

DO YOU BLEED EXCESSIVELY WHEN CUT?_______________________

ARE YOU TAKING ANY MEDICATION, PILLS, OR DRUGS? IF SO, PLEASE

LIST:____

____

DO YOU SUFFER FROM ANY OF THE FOLLOWING CONDITIONS?
MITRAL VALVE PROLAPSE___HEART DISEASE___DIABETES______

HIGH BLOOD PRESSURE___STROKE___BLOOD DISEASE__________

HEART MURMUR___RHEUMATIC FEVER____ASTHMA___________

RADIATION TREATMENT_____LIVER AND KIDNEY DISEASE________

ARE YOU ON DIALYSIS____TUMOR HISTORY____HEPATITIS_____

EPILEPSY_____ARTHRITIS_____HIV____CHEMOTHERAPY_________

JOINT REPLACEMENT?________KNEE___HIP____SHOULDER_____

OTHER REPLACEMENT______PINS/SCREWS____________________

ARE YOU ALLERGIC TO PENNICILLIN?_____LATEX____ASPIRIN___

DENTAL ANESTHETICS_____OTHERS__________________________

WOMEN

ARE YOU PREGNANT?___________NURSING?____________________

DENTAL HISTORY

PREVIOUS DENTIST_________________LAST SEEN_______________

DO YOU HAVE ANY PRESENT DENTAL COMPLAINTS?____________

____

ARE YOU HAPPY WITH YOUR SMILE?__________________________

WHEN WAS YOUR LAST SET OF X-RAYS TAKEN?_________________

WHEN WAS YOUR LAST CLEANING?____________________________

HAVE YOU EVER BEEN INSTRUCTED IN THE PREVENTION OF DECAY

AND CARING FOR YOUR GUMS?_______________________________

I HEREBY STATE THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I HEREBY CONSENT TO DR. SHERESE LEONARD TO DETERMINE AND PERFORM NECESSARY AND HEALTHFUL DENTAL PROCEDURES FOR THE PATIENT LISTED ABOVE. I UNDERSTAND THAT MY INFORMATION WILL BE KEPT CONFIDENTIAL.

SIGNATURE________________________________DATE________________

OUR OFFICE FINANCIAL ARRANGEMENTS

PLEASE READ THE FOLLOWING CAREFULLY:

IN AN EFFORT TO PROVIDE YOU WITH QUALITY DENTAL CARE AND PAYMENT ARRANGEMENTS, WE HAVE EXPANDED OUR PAYMENT POLICIES.

PAYMENT AGREEMENTS ARE EXPECTED TO BE MADE AT THE TIME OF EACH VISIT FOR SERVICES RENDERED. PAYMENT AGREEMENTS ARE NOT ABLE TO BE EXTENDED PAST 3 MONTHS FROM THE START DATE OF TREATMENT.

WE OFFER THE FOLLOWING PAYMENT OPTIONS FOR YOUR CONVENIENCE:

CASH
CHECK
CREDIT CARD
THIRD PARTY FINANCING

PLEASE UNDERSTAND THAT EVEN THOUGH YOU MAY HAVE DENTAL INSURANCE, THERE ARE STILL DEDUCTIBLE AND CO-INSURANCE AMOUNTS FOR WHICH YOU ARE RESPONSIBLE. PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED.

$50 MINIMUM ON CHARGE/DEBIT CARDS

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PATIENT'S SIGNATURE

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DEER PARK, NEW YORK 11729
631-667-7778

HIPPA BUSINESS ASSOCIATE AGREEMENT
FOR THE OFFICE OF DR. SHERESE LEONARD

EXCEPT AS OTHERWISE LIMITED BY THIS AGREEMENT, OR ANY LAW, DR. LEONARD MAY USE AND DISCLOSE **PROTECTED HEALTH INFORMATION** (PHI) FOR THE PURPOSE OF ATTEMPTING TO PROPERLY CARE FOR THE INDIVIDUAL TO WHOM THE INFORMATION RELATES. DR. LEONARD MAY ALSO USE PHI FOR THE PROPER MANAGEMENT AND ADMINISTRATION OF SUCH INFORMATION.

DR. LEONARD'S PRIVACY POLICY PROVIDES SPECIFICS ABOUT THE INFORMATION DR. LEONARD COLLECTS AND HOW IT IS TO BE USED AND/OR DISCLOSED.

ALL TERMS IN THIS AGREEMENT SHALL BE CONSTRUCTED IN LIGHT OF REGULATIONS AND COURT DECISIONS CONSTRUING THE PROVISIONS OF THE **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT.**

DR. LEONARD AGREES:

NOT TO USE OR DISCLOSE **PHI** OTHER THAN SPECIFIED ABOVE.

TO USE THE APPROPRIATE SAFEGUARDS TO PREVENT USE OR DISCLOSURE OF **PHI** OTHER THAN IT'S SPECIFIED USE.

TO MITIGATE, TO THE EXTENT PRACTICABLE, ANY HARMFUL EFFECT THAT IS KNOWN TO DR. LEONARD OF A USE OR DISCLOSURE OF **PHI** BY DR. LEONARD BEYOND THOSE SPECIFIED ABOVE.

TO REPORT TO PATIENT ANY USE OR DISCLOSURE OF **PHI** NOT PROVIDED FOR BY THIS AGREEMENT OF WHICH HE BECOMES AWARE.

TO ENSURE THAT BUSINESS ASSOCIATES, INCLUDING A SUBCONTRACTOR, TO WHOM DR. LEONARD PROVIDES **PHI,** AGREES TO THE SAME RESTRICTIONS AND CONDITIONS THAT APPLY TO DR. LEONARD.

TO PROVIDE ACCESS, AT PATIENT'S EXPENSE, AT DR. LEONARD'S OFFICE UPON REASONABLE NOTICE TO PATIENT'S ACCOUNT RECORDS, AND DR. LEONARD'S POLICIES AND PROCEDURES RELATIVE TO AND MAINTIANING THE PRIVACY OF **PHI.**

TO MAKE AMENDMENT(S) TO **PHI** AS REQUIRED BY **HIPPA.**

TO DOCUMENT DISCLOSURES OF **PHI** AND INFORMATION RELATED TO SUCH DISCLOSURES AS WOULD BE REQUIRED FOR CLIENT TO RESPOND TO A REQUEST BY AN INDIVIDUAL FOR AN ACCOUNTING OF DISCLOSURES OF **PHI** IN ACCORDANCE WITH **HIPPA** REGULATIONS, AND TO PROVIDE THIS INFORMATION TO PATIENT AS NEEDED BY PATIENT.

TO FOLLOW THESE REQUIREMENTS FOR SO LONG AS DR. LEONARD MAINTAINS **PHI** IN ANY FORM, EVEN IF DR. LEONARD IS NO LONGER PROVIDING ON-GOING SERVICES FOR PATIENTS (DR. LEONARD WILL MAINTAIN INFORMATION IN OUR FILES FOR AT LEAST 7 YEARS FROM THE DATE OF LAST CONTACT WITH AN INDIVIDUAL).

ASSOCIATE UNDERSTANDS: DR. LEONARD WILL ASSUME THAT BUSINESS ASSOCIATE HAS NOT AGREED TO SPECIAL LIMITATIONS OF **PHI** DISCLOSURES FOR ANY PATIENT UNLESS ASSOCIATE INFORMS DR. LEONARD. ASSOCIATE UNDERSTANDS THAT DR. LEONARD MAY REFUSE TO PROVIDE **PHI** IF WE FEEL THAT ASSOCIATE IS NOT PERFORMING IT'S SERVICES.

AGREED:

DATED: