Millennium Dental Services, P.C.

Yin-Yin Shang, D.D.S.

2 W. 45th Street, Suite 1600
New York, NY 10036

Today's Date: ____/____/____

Patient Name: _____ Title: ☐ Mr. ☐ Dr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ None
First Middle Last

Date of Birth: ____/____/____

Home Address: _____
Street (Include Apt. #) City State Zip

Telephone #: Home ( ) _____-_____ Patient SS#: _____-_____-_____ Sex: ☐ Male ☐ Female

Work ( ) _____-_____ Email Address (if any): _____

Cell ( ) _____-_____ Referred By: _____

Insurance Subscriber Information (If Subscriber is NOT patient)

Subscriber Name: _____ Title: ☐ Mr. ☐ Dr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ None Date of Birth: ____/____/____
First Middle Last

Home Address / Phone #: _____
Street (Include Apt. #) City State Zip Phone#

Subscriber SS#: _____-_____-_____ Sex: ☐ Male ☐ Female Relationship to Patient: _____

Subscriber Employment Information

Employer Name: _____ Employee ID (if different SSN): _____-_____-_____

Employee Address: _____
Street (Include Suite #) City State Zip

Insurance Information

Insurance Company Name: _____ Group or Plan No: _____

Secondary Insurance Co. Name: _____ Group or Plan No: _____

Medical Insurance Co. Name: _____ Group or Plan No: _____

Authorization to Release Information. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize the release of any information relating to my dental claims.

_____ ____/____/____
Signature Date (MM/DD/YYYY)

Authorization to Pay Benefits to Dentist. I hereby authorize payment of the dental benefits, otherwise payable to me directly, to Millennium Dental Services, P.C.

_____ ____/____/____
Signature Date (MM/DD/YYYY)

Welcome to Millennium Dental Services, P.C.. Please briefly tell us why you are here today, including any concerns that you have.

_____

_____

When was your last cleaning and x-rays taken? _____ Where? _____

Medical History

Name / Address / Phone # of Physician: _____

Are you in good health? _____ If no, explain _____

Do you have an existing illness? _____ If yes, explain _____

Have you been hospitalized in the past two years? _____ If yes, explain _____

Do you bleed excessively when cut? _____ Do you smoke? _____ If yes, how much? _____

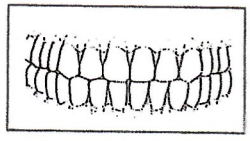
Are you taking any medication, pills or drugs? _____ If yes, please list: _____

Do you now have, or have you had any of the following? (If yes, please describe)

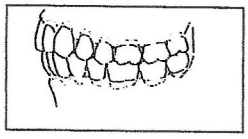
		YES	NO			YES	NO	TYPE
1.	Heart Disease	☐	☐	14.	Liver Disease	☐	☐	
2.	High Blood Pressure	☐	☐	15.	Kidney Disease	☐	☐	
3.	Blood Disease	☐	☐	16.	Hepatitis	☐	☐	
4.	Rheumatic Fever	☐	☐	17.	Asthma	☐	☐	
5.	Heart Murmur	☐	☐	18.	Tuberculosis	☐	☐	
6.	Diabetes	☐	☐	19.	AIDS or HIV positive	☐	☐	
7.	Stroke	☐	☐	20.	Allergy to: (a) Penicillin	☐	☐	
8.	Epilepsy	☐	☐		(b) Other Antibiotics	☐	☐	_____
9.	Arthritis	☐	☐		(c) Local Anesthetics	☐	☐	_____
10.	Tumor History	☐	☐		(d) Other	☐	☐	_____
11.	Venereal Disease	☐	☐	21.	Are you pregnant?	☐	☐	
12.	Nervous Disorders	☐	☐	22.				
13.	Radiation Treatment	☐	☐					

Smile Evaluation

1. Do you like the appearance of your teeth; your smile? ☐Yes ☐No
   If not, explain _____

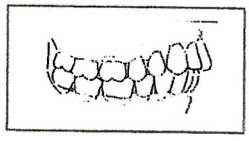


2. Are your teeth all in alignment (straight)? ☐Yes ☐No
   If not, explain _____



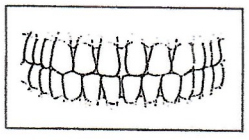
3. Do you have spaces that you don't like? ☐Yes ☐No
   If yes, explain _____

4. Do you like the color of your teeth? ☐Yes ☐No
   If not, explain _____



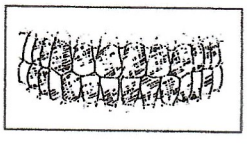
5. Do you like the shape of your teeth? ☐Yes ☐No
   If not, explain _____

6. Are your teeth....
   chipped? _____ protruding? _____ hidden? _____



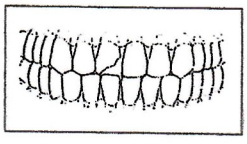
7. Are your teeth wearing on the biting surfaces? ☐Yes ☐No
   If yes, explain _____

8. Are there old fillings or dental work you don't like looking at? ☐Yes ☐No
   If yes, explain _____



9. What would you like to change the most in the appearance of your teeth?
   _____
   _____

10. How would you like your teeth to look?
    _____
    _____



HIPAA Notice of Privacy Practices

MILLENNIUM DENTAL SERVICES, P.C.
2 W. 45th Street, Suite 1600
New York, New York 10036
(212) 730-6900

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____