UNIONSMILES family & cosmetic dentistry

| | Dr. Umut Caglar, DDS. PA
| | 2333 Morris Ave., C101
| | Union, NJ 07083

NEW PATIENT FORMS
INTAKE, HIPAA, PRIVACY NOTICE

Patient Information:

Last:		First:		M:
Sex (Check One): ☐Male ☐Female	Marital Status (Check One): ☐Single ☐Married ☐Widow ☐ Separated ☐Divorced			Age:
Date of Birth (mm/dd/yy) / /	Driver's License#:		SS#: - -	
Address:	Apt. #	City:	State:	Zip:
Email:	Home Phone: ( ) -	Cell: ( ) -	Preferred Method of Contact: ☐Email ☐Home # ☐ Cell ☐ Work #	
Occupation:	Employer:	Work Phone: ( ) -		
Employer Address:	City:	State:	Zip:	

Complete if person responsible for payment different from the patient/if patient is minor:

Name of Responsible Party:	Relationship to Patient:		
Street Address:	City:	State:	Zip:
Email:	Home Phone: ( ) -	Cell Phone: ( ) -	Preferred Method of Contact: ☐Email ☐Cell # ☐Home # ☐Work #
Occupation:	Employer:	Work Phone: ( ) -	
Employer Address:	City:	State:	Zip:

Insurance Information:

PRIMARY INSURED

Last:	First:		M:
Street:	City:	State:	Zip:
Birthdate (mm/dd/yy): / /	Relationship to Patient:	Phone #:	
Employer:	Work Phone:	Dental Insurance Company:	
SS #: - -	Subscriber #:	Group #:	

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SECONDARY INSURED			
Last:	First:		M:
Street:	City:	State:	Zip:
Birthdate (mm/dd/yy): / /	Relationship to Patient:	Phone #:	
Employer:	Dental Insurance Company:	Work Phone:	
SS #: - -	Subscriber #:	Group #:	

Emergency Contact:
Name:
Address:
City/State/Zip:

Phone #: ( ) -

Has any member of your family ever been a patient at our office?
☐ Yes ☐ No

Name:

Authorization:
Our office policy requires payment in full at time of the service unless other financial arrangements are made with our office prior to service. If the balance is not paid in full of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting on your account.

"I understand the above information and I sign that this form was completed correctly to the best of my knowledge. I authorize Dr. Umut Caglar, D.D.S. and his licensed staff to perform any necessary procedures needed during diagnosis and treatment within scope of their license. I authorize the provider to release any information required to process insurance claims. I understand it is my responsibility to inform this office of any changes. I hereby authorize the dental office to administer any needed medications and procedures if needed for proper dental care."

X_____

Patient or Responsible Party

_____/_____/_____ _____

Whom may we thank for your referral?

☐ Patient Name:

☐ Dr.

☐ Other

Method of Payment:

Responsible party has account with this office
☐ Yes ☐ No

☐ Payment in full at each appointment:
- ☐ Cash/Check
- ☐ Credit Card
  - Card#:
  - Exp Date: _____/_____/_____
- ☐ CareCredit (Requires credit approval)

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Date (mm/dd/yyyy)	**State Driver's License #**	

Medical and Dental History:

Physician's Name:	Physician's Phone#: ( ) -	Date of last complete physical: / / *(mm/dd/yy)*	
Physician's Address:	City:	State:	Zip:

Are you taking any medications, vitamins, or supplements? ☐Yes ☐No

If yes, please list:

For what purpose?

Are you pregnant? ☐Yes ☐No | If yes, how many months?

Are you allergic to:
☐Latex ☐Tetracycline ☐Tylenol ☐Aspirin ☐Local Anesthesia ☐Penicillin/Amoxicillin ☐Codeine

Please list any other allergies:

Do you have or have you ever had any of the following?

	Yes	No		Yes	No
Arthritis/Artificial joints	☐	☐	Breathing issues	☐	☐
Radiation therapy	☐	☐	AIDS/HIV+	☐	☐
Malignancies	☐	☐	Prolonged bleeding	☐	☐
Heart murmur/MVP/Rheumatism	☐	☐	Headache, neck, jaw pain, or TMJ	☐	☐
Conditions requiring blood thinners	☐	☐	Psychiatric care	☐	☐
Anemia	☐	☐	High blood pressure	☐	☐
Ulcers	☐	☐	Tuberculosis	☐	☐
Sinusitis	☐	☐	Epilepsy	☐	☐
Herpes	☐	☐	Jaundice/Hepatitis	☐	☐
Asthma	☐	☐	Vertigo	☐	☐
Neck pain	☐	☐	Sensitivity to epinephrine	☐	☐

Do you ever get head, neck, or facial pain? ☐Yes ☐No
If yes, describe your pain and list how often:

Please describe any additional medical/dental conditions you have and/or use this space to expand on any selected above:

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Family Member Information

Please list the name of your spouse and children.	Is person a patient?		Sex		Age	Please list the name of your spouse and children.	Is person a patient?		Sex		Age
	Yes	No	M	F			Yes	No	M	F	
	☐	☐	☐	☐			☐	☐	☐	☐	
	☐	☐	☐	☐			☐	☐	☐	☐	
	☐	☐	☐	☐			☐	☐	☐	☐	
	☐	☐	☐	☐			☐	☐	☐	☐	
	☐	☐	☐	☐			☐	☐	☐	☐	

Dental Health History

1. On a scale of 1-10 (10 being the worst, please rate your dental anxiety):
2. Do you ever experience any of the following?:

Bleeding gums ☐Yes ☐No	Dry Mouth ☐Yes ☐No
Bad breath ☐Yes ☐No	Sensitivity to hot & cold ☐Yes ☐No
Jaw soreness/TMJ ☐Yes ☐No	Teeth grinding ☐Yes ☐No
Loose teeth ☐Yes ☐No	Food stuck between teeth ☐Yes ☐No

3. If you would change anything about your smile, what would you change?

Whiter teeth/teeth color ☐Yes ☐No	Replace fillings ☐Yes ☐No
Replace missing teeth ☐Yes ☐No	Space(s) ☐Yes ☐No
Reshape/resize teeth ☐Yes ☐No	Replace old/chipped crowns ☐Yes ☐No
Straighten smile ☐Yes ☐No	Fix bondings ☐Yes ☐No

4. Is there anything else that you would like to share with Dr. C regarding your visit today?

HIPAA 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. This Notice provides you with information to protect the privacy of your confidential health care information, hereafter referred to as protected health information (PHI). The Notice also describes the privacy rights you have and how you can exercise those rights. Please review it carefully.

If you have any questions about this Notice, please contact Dr. Umut M. Caglar at 908-686-5277.

OUR COMMITTMENT REGARDING YOUR PERSONAL HEALTH INFORMATION

Union Smiles Dentistry is committed to maintaining and protecting the confidentiality of our employees' personal information. This Notice of Privacy Practices applies to Union Smiles Dentistry dental plans collectively, the Plans. The Plans are required by federal and state law to protect the privacy of your individually identifiable health information and other personal information. We are required to provide you with this Notice about our policies, safeguards and practices. When the Plans use or disclose your PHI, the Plans are bound by the terms of this Notice, or the revised Notice, if applicable.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Dr. Umut M. Caglar at umutcaglardds@gmail.com. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Dr. Umut M. Caglar at umutcaglardds@gmail.com.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Dr. Umut M Caglar at umutcaglardds@gmail.com.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Dr. Umut Caglar at umutcaglardds@gmail.com. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Dr. Umut M. Caglar at umutcaglardds@gmail.com. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.unionsmilesdentistry.com. To obtain a paper copy of this notice, contact Umut M. Caglar, DDS at umutcaglardds@gmail.com.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Dr. Umut Caglar at umutcaglardds@gmail.com. All complaints must be made in writing. You will not be penalized for filing a complaint.

You may contact our office at:

- Dr. Umut Caglar
- umutcaglardds@gmail.com
- Union Smiles Dentistry, 2333 Morris Avenue Ste. 101, Union, New Jersey 07083.
- (908) 686-5277

The Plans may change the terms of this Notice at any time. If the Plans change this Notice, the Plans may make the new Notice terms effective for all of your PHI that the Plans maintain, including any information the Plans created or received before we issued the new Notice. If the Plans change this Notice, the Plans will make it available to you.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices/to document our effort to obtain acknowledgement.

You May Refuse to Sign This Acknowledgement

I, _____*(print full name)*, have received a copy of this office's Notice of Privacy Practices.

Sign: _____

Date: _____

Authorization to Release Information:
This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself.

I, _____ authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____
[Name/Relationship]

_____
[Name/Relationship]

_____
[Name/Relationship]

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 acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)