David J. Martin DDS, MAGD
Debra M. Ferraiolo DMD, FAGD

The Art of Making Your Smile More Beautiful!

336 Union Boulevard • Totowa, NJ 07512
Phone: (973) 942-6467 • Fax: (973) 942-7763
www.davidjmartindds.com

WELCOME TO OUR PRACTICE

Both of our doctors are here to provide for your dental health needs as thoroughly and as efficiently as possible so that you may enjoy the many benefits of good dental health.

WHAT TO EXPECT ON YOUR FIRST VISIT

Unless you are coming to the office for a special procedure, you can expect your initial visit will be spent taking a full mouth series of x-rays, blood pressure, a complete prophy (cleaning), periodontal charting and thorough oral exam. A thorough examination will enable us to determine a practical treatment plan for you. The treatment plan will tell you what procedure is needed, why it is necessary, how much it will cost and how long treatment will take. If there is more than one method of treatment to be considered, each will be discussed as well as what can be expected from each type of service.

What to Bring: On your first visit, it is important that you bring any records that are important to your condition, including any recent x-rays that you have had. If you have any problems in obtaining your x-rays, please contact this office prior to your first visit.

Insurance and Financial: Please bring your insurance identification card (indicating the name of the insurance company, address and group number) with you at the time of your visit. We expect payment at the time of service. For your convenience, we accept American Express, Discover, Visa and Mastercards. We shall gladly submit your insurance forms directly to your insurance company via the mail or electronic transmission. To avoid any misunderstanding, please contact one of our team members, they have complete charge of all appointments. We have a variety of financial options available for your convenience.

Parking: Parking may be a problem. We suggest that you allow ample time to find a suitable parking space.

The most important service we have is our plan for preventive dentistry. We now know that there is no need for constantly recurring decay and gum disease. We also know that, with proper home care, virtually all dental disease can be prevented BY THE PATIENT! We are anxious to help you get started on this preventive "plaque control program".

For your convenience, directions to our office are provided below. We look forward to seeing you and assisting you with your dental care.

Yours in dental health,

DAVID J. MARTIN, DDS, PA, MAGD,
DEBRA M. FERRAIOLO, DMD, FAGD & STAFF

ROUTE 80 WEST: Take the exit for Union Boulevard Totowa. Continue down Union Boulevard through two traffic lights. We are located on the right hand side approximately ¼ mile down.

ROUTE 80 EAST: Take Exit 54, Minnisink Road - Little Falls. Make a left turn onto Minnisink Road. Go over the overpass. Travel straight down until you cannot go any more. Make a right turn onto Totowa Road. Continue straight down Totowa Road to the traffic light. Make a left turn onto Union Boulevard. We are located on the right hand side approximately ¼ mile down.

ROUTE 46 WEST: Take the exit for Union Boulevard Totowa. Make a right turn onto Union Boulevard. Continue down Union Boulevard through four traffic lights. We are located on the right hand side ¼ mile after the fourth traffic light.

ROUTE 46 EAST: Take the exit for Union Boulevard Totowa. Travel down Union Boulevard through four traffic lights. We are located on the right hand side approximately ¼ mile after the fourth traffic light.

DAVID J. MARTIN, DDS, PA, MAGD
DEBRA M. FERRAIOLO, DMD, FAGD

336 UNION BOULEVARD, TOTOWA, NEW JERSEY 07512
PHONE (973) 942 – 6467 FAX (973) 942 – 7764
DAVIDJMARTINDDS.COM

THE ART OF MAKING YOUR SMILE MORE BEAUTIFUL!

WELCOME

Name:	**Birthdate:**	**Age:**	**Sex:** F M
Residence Address:			
Home Phone #:	**Mobile #:**	**Email:**	
Social Security #:	**Driver's License # & Expiration:**		
Patient Employed By:	**Business Phone #:**		
Business Address:			

Who Is Responsible For This Account?

Method of Payment - Please Circle:

Cash Credit Card Check

Expectations of Today?

Whom May We Thank For This Referral?

Name & Telephone # of Someone Not Living With You to Notify in Case of Emergency:

I have read the information given to me and understand it. I also state that I read and write in English.

Signature: **Today's Date:**

Consent & Release:

It has been explained, in terms clear to me, the effects and nature of the procedure(s) to be performed, foreseeable risks involved, and alternative methods of treatment. I have been given the opportunity to ask any questions regarding elective cosmetic procedures and my questions have been answered satisfactorily. I am aware that there are certain inherent and potential risks and side effects in any invasive procedure. I understand that this is an elective procedure and I hereby voluntarily consent to the treatment. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure.

I have been advised that the goal of the procedure I have requested is improvement in the appearance, not perfection, that there is a possibility that imperfections might ensue, and that the results might not meet my expectations or the goals that have been established. In relation to this I know that this is not an exact science and that, therefore, no guarantee or assurance has been made by anyone regarding the procedure which I have herein requested and authorized.

I understand that if the doctor judges at any time that my procedure should be postponed or canceled for any reason, he/she may do so.

I authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentations.

I understand that this is an elective cosmetic procedure and that payment is my responsibility and is expected at the time of treatment.

I understand that I have the right to discontinue treatment at any time.

PATIENT MEDICAL HISTORY FOR FACIAL ESTHETICS

Name:	Birthdate:
Have You Ever Had Facial Enhancement? Y N If so, Please List:	
Name of Your Physician:	**Physician Phone #:**
Are You Taking Any Medications: Y N If So, Please List:	

Are You Allergic to Any Food/Medications? Please Circle:

Y	N	Aspirin	Y	N	Jewelry
Y	N	Codeine	Y	N	Latex
Y	N	Dental Anesthetics	Y	N	Penicillin/Other Antibiotics
Y	N	Toxin Ingredients/Human Albumin	Y	N	Other Allergies, Please List:

Pregnancy & Neurologic Disease: Y N
I am not aware that I am pregnant and I am not trying to get pregnant, I am not lactating (nursing). I do not have any significant neurologic disease including but not limited to Myasthenia Gravis, MS, ALS, Lambert-Eaton Syndrome & Parkinson's

Do You Have, or Have You Ever Had? Please Circle:

Y	N	Abnormal Bleeding	Y	N	Heart Attack/Surgery
Y	N	Alcohol/Drug Abuse	Y	N	Heart Valve Replacement
Y	N	Anemia	Y	N	Hepatitis
Y	N	Anxiety	Y	N	Joint Replacement
Y	N	Autoimmune Disease	Y	N	Kidney Problems
Y	N	Bacterial Endocarditis	Y	N	Liver Disease
Y	N	Bisphosphonates	Y	N	Pacemaker
Y	N	Blood Thinner	Y	N	Pain in Jaw Joint/Muscles
Y	N	Bruise Easily	Y	N	Psychiatric Problems
Y	N	Cancer	Y	N	Radiation/Chemo Therapy
Y	N	Cholesterol Issues	Y	N	STDs
Y	N	Congenital Heart Defect	Y	N	Seizures
Y	N	Cough	Y	N	Serum Sickness
Y	N	Diabetes	Y	N	Shingles
Y	N	Difficulty Breathing	Y	N	Sinus Problems
Y	N	Emphysema	Y	N	Smoke/Tobacco
Y	N	Epilepsy	Y	N	Steroid Therapy
Y	N	Fainting Spells	Y	N	Stomach Problems
Y	N	Fever Blisters	Y	N	Stroke
Y	N	Frequent Headaches	Y	N	Thyroid Problems
Y	N	Glaucoma	Y	N	Tuberculosis
Y	N	HIV+/AIDS			
Y	N	Do You Have Any Other Medical Condition That is Not Covered Above? If So, Please List:			

Comments:

I attest to the accuracy of the information on this page. I certify that if I have any changes in this medical history I will notify the office immediately.

Signature: **Today's Date:**

DAVID J. MARTIN, DDS, PA, MAGD
336 UNION BOULEVARD, TOTOWA, NJ 07512

DEBRA M. FERRAIOLO, DMD, FAGD
(973) 942 – 6467, FAX (973) 942 – 7763

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law

- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Insert Effective Date of this Notice
- Insert name or title of the privacy official (or other privacy contact) and his/her email address and phone number.
- Insert any special notes that apply to your entity's practices such as "we never market or sell personal information."
- The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, "We will never share any substance abuse treatment records without your written permission." Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.
- If your entity provides patients with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.
- If your entity is part of an OHCA (organized health care arrangement) that has agreed to a joint notice, use this space to inform your patients of how you share information within the OHCA (such as for treatment, payment, and operations related to the OHCA). Also, describe the other entities covered by this notice and their service locations. For example, "This notice applies to Grace Community Hospitals and Emergency Services Incorporated which operate the emergency services within all Grace hospitals in the greater Dayton area."

DAVID J. MARTIN, DDS, PA ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

SECTION A: The Patient

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Date of Birth: _____ Social Security Number: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

SECTION C: AUTHORIZATION:

I authorize the following individuals to be informed on my behalf:

_____ Relationship: _____

_____ Relationship: _____

SECTION D: Good Faith Effort to Obtain Acknowledgement of Receipt

Describe your good faith effort to obtain the individual's signature on this form: _____

_____

_____

Describe the reason why the individual would not sign this form: _____

_____

_____

SIGNATURE:

I attest that the above information is correct.

Signature: _____ Date: _____

Print Name: _____ Title: _____