

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____ City _____ State _____ Zip _____

Email _____ Home Phone _____ Cell Phone _____

Preferred method of contact for appointment reminders: Home Phone Cell Phone (text)** Email **

Sex M F Age _____ Birth date _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____ Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____ Email _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birth date _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Email _____ Person Responsible Employed by _____

Occupation _____ Business Address _____

Business Phone _____ Business Email _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birth date _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

- Please complete other side -

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad breath | <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting |
| <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot | <input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth |

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y N

Other information about your dental health or previous treatment _____

Medical History

Physician's name: _____ Phone _____ Date of last visit _____

Have you had any serious illnesses or operations? Y N

If yes, describe _____

Are you currently under physician care? Y N If yes, describe _____

Have you ever had a blood transfusion? Y N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? Y N

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check (✓) yes or no whether you have had any of the following:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive | <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis | <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Material allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/
Heart surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone) | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or malfunction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease | <input type="checkbox"/> Y <input type="checkbox"/> N Heart problems | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | Describe _____ | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/ | | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes | | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis | <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems | | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease | <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments | | |

Is patient currently taking any medications? If yes, list all: _____

Does patient have drug allergies? If yes, list all: _____

Authorization & Financial Policy

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge I understand that this information will be used by Dr. Mancuso to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform Dr. Mancuso.

I authorize the insurance company indicated on this form to pay Dr. Mancuso all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Dr. Mancuso to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not they are paid by my insurance provider.

I understand and agree that payment must be made in full at time of treatment, or by the due date on my statement. If payment is not received by that date, I will be charged a late fee of \$25.00 _____ (initial), plus interest charges of 1 1/2% per month, 18% per annum _____ (initial). In the event of non-payment, I agree to be responsible for all costs of collections, including attorney fees and court costs. _____ (initial).

**Caution: If you elected to communicate with our office electronically, there is some level of risk that third parties may be able to read unencrypted messages which could expose your identity and personal health information.

Signature _____ Date _____

PAYMENT AGREEMENT FOR PATIENTS WITH DENTAL INSURANCE THAT DR. MANCUSO IS NOT A PARTICIPATING PROVIDER

Thank you for choosing our office as your dental healthcare provider. The following guidelines explain our Financial Policy which requires your approval prior to receiving treatment.

While we will always do our best to help you maximize your insurance benefits, our primary focus is on providing you with dental treatment that best meets your needs. Since dental insurance plans do not correspond to individual needs, many routine and necessary dental services may not be covered by your insurance plan even though you may be best treated with those services.

1. We will submit to your dental insurance carrier and accept the assignment (payment) of insurance benefits, provided we have your current credit card information on file along with authorization to charge that card in the event you have a remaining balance unpaid by your insurance company.
2. Dental insurance companies will provide an estimate of coverage, including the out-of-pocket costs for treatment. This estimated amount is due at the time of your service. Once your insurance claim is processed we can determine if they made any changes to your out-of-pocket expenses. In the event there is an additional payment due; we will notify you by statement. You will always be given the option which form of payment to use to this balance. In the event of an overpayment, we will return those funds to you, or you may apply them towards future services.
3. The claims we submit to your insurance will indicate that you have assigned those benefits to Dr. Mancuso. However, if you are paid directly by the insurance company, you then become responsible for your total unpaid account balance and payment is due immediately.
4. Most dental insurance plans have annual benefit limitations. If you exceed your annual limitation, you are responsible for the full amount that was exceeded. In addition, if you do not utilize these benefits in your plan year, those benefits are lost and cannot be carried over to future years.
5. Patients are responsible for any charges not covered by their insurance provider.
6. We accept checks, cash, Visa, MasterCard, Discover, and American Express.
7. Checks returned to our office unpaid will be subject to a fee of \$35.00.
8. Your reserved appointment time is important for your successful care. We understand that sometimes it is necessary to change an appointment so we ask that you give us at least 2 business days notice. Patients who continually break appointments will be dismissed from our practice.
9. Credit Card Authorization – As you know, if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company since it makes checkout easier, faster, and more efficient. We have implemented a similar policy.

You will be asked for a credit card number at the time you check in and the information will be held securely until your insurance provider has paid their portion of your treatment cost which determines your out-of-pocket expenses. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.

The advantage to you is you no longer need to write out and mail us checks. The advantage to us is it will decrease the number of statements we send out. The combination will benefit everybody in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays due at the time of the visit will still be due at the time of the visit.

If you have any questions about this payment method, do not hesitate to ask.

10. In the event a patient defaults on their obligation to pay for services, a late fee of \$25.00 per month, as well as interest charges of 1-1/2% per month (18% per year) will be charged to their account until the account is brought up to date. _____ (initial) In the event a patient's account is turned over to collections, the patient will be responsible for all costs of collection fees (approx. 40%), as well as reasonable attorney fees and court costs. _____ (initial).

AGREEMENT TO FINANCIAL POLICY

I authorize MARY T. MANCUSO, DMD, PA to charge outstanding balances on my account to the following credit card:

Visa MasterCard American Express Discover (circle one) Billing Zip Code _____

Account number _____ Expiration Date _____ CVV _____

Name on card (please print) _____

I, _____ have read and agree to this Financial Policy on _____.
(Name) (Date)

Signed: _____
(Signature)

Mary T. Mancuso, DMD, PA

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

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect.

This Notice takes effect February 16, 2026, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example.

Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Special Protections for Substance Use Disorder Treatment Records

Federal law provides special privacy protections for certain records related to substance use disorder (SUD) diagnosis, treatment, or referral for treatment under 42 U.S.C. §290dd-2 and 42 CFR Part 2.

Our practice is **not** a substance use disorder treatment program. However, we may receive, maintain, or transmit records that are subject to these additional federal protections.

When applicable:

- Substance use disorder treatment records may not be used or disclosed without your written authorization, except as permitted by law.

- A single written authorization may permit future uses and disclosures for treatment, payment, and health care operations.
- These records may not be disclosed in civil, criminal, administrative, or legislative proceedings without specific patient consent or a court order that complies with federal law.
- These records may not be used in criminal investigations or prosecutions against you without a court order.
- You have the right to revoke your authorization in writing, subject to limited exceptions.

Where Part 2 applies, it provides additional privacy protections beyond those provided by HIPAA.

Treatment: We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment: We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care: We may disclose your health information to your family or friends, or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

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

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors: We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising: We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting: With the exception of certain disclosures, including those made for treatment, payment, health care operations, or pursuant to a valid authorization, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. If applicable, this right also applies to certain disclosures of substance use disorder treatment records protected under 42 CFR Part 2. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction: You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach: You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice: You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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 Our Privacy Official:

Paul Englander
27-11 Pellack Drive | Fair Lawn NJ 07410
Telephone: 201-796-7171 | Fax: 201-796-0600
Email: admin@drmarymancuso.com

MARY T. MANCUSO, DMD PA

27-11 Pellack Dr Fair Lawn NJ 07410

info@DrMaryMancuso.com

NOTICE OF PRIVACY PRACTICES RECEIPT OF ACKNOWLEDGEMENT

HIPAA requires dentists to deliver a Notice of Privacy Practices statement to all their patients. You may download our statement from our website (under "New Patient Documents"), receive a physical paper copy, or have a PDF copy sent to your email or mobile number. Please indicate how you would like to receive your notice. Please select ONE from the following:

- **I Will Download it From Your Website**
- **Please Email a Copy** Email Address: _____
- **Please Text me a Copy** Mobile Phone Number: _____ Provider _____
- **Please Send Me a Paper Copy**

I, _____ have received a copy of the NOTICE OF PRIVACY PRACTICES of this office. I am aware that additional copies are available to me anytime at my request. Please Note: It is your right to refuse to sign this acknowledgement.

Patient's Signature: _____ Date: _____

THIS SECTION IS FOR OFFICE USE ONLY-

We tried to obtain written acknowledgement by the individual noted above of receipt of our NOTICE OF PRIVACY PRACTICES, but it could not be obtained because:

- An emergency prevented us from obtaining acknowledgement.
- A communication barrier prevented us from obtaining acknowledgement.
- The individual was unwilling to sign.
- Other:

Employee's Name: _____ Date: _____