ANTHONY T. DIOGUARDI, D.M.D.
*Diplomate of the American Board of Dental Sleep Medicine*

Crown Tower
123 York Street
New Haven, CT 06511
Tel: (203) 777-2513
Fax: (203) 776-1714

We would like to welcome you to our practice.

Our office hours are 8:30 a.m. to noon and 1 p.m. to 5 p.m. Monday through Friday except for Wednesday when our office hours are 8:30 a.m. to noon.

We have enclosed forms for you to complete and bring with you to your first appointment. If you have medical insurance, it is extremely important that you bring a copy of your insurance card with you; this information is required for us to submit a request for preauthorization to your insurance company or to submit a claim for payment.

Most medical insurance companies will pay toward sleep apnea treatment. We work with all private insurance companies and are in network with Medicare, Aetna, Cigna, Connecticare and United Healthcare. We also accept several payment options including flex-spending accounts, health savings accounts and CareCredit.

If a sleep study has been conducted, please contact that physician or sleep center as soon as possible and have that report faxed to us at (203) 776-1714 along with a referral and/or prescription. We will need this information for your appointment along with a copy of either a full mouth series of xrays or panoramic film from your dentist. If the xrays are digital, they can be emailed to: dental123york@gmail.com.

Also enclosed is a set of directions to our office. If you have any questions, please do not hesitate to contact us.

We look forward to meeting you.

# PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. **Please print.** All information will be confidential.

Date _____ Patient Name _____ (FIRST MI LAST) Patient # _____

SS #/SIN _____ ☐ Male ☐ Female Birthdate _____ Home phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

E-Mail _____ Cell Phone _____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or parent/guardian's employer _____ Work phone _____

Business address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or parent/guardian's name _____ Employer _____ Work phone _____

If patient is a student, name of school/college _____ City _____ State/Prov. _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

In case of a medical emergency, if the patient is of school age 15+, it is all right to treat in my absence.

X _____ _____

Parent or guardian signature — Date

## Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

E-Mail _____ Cell phone _____

Driver's license # _____ Birthdate _____ Financial institution _____

Employer _____ Work phone _____

Is this person currently a patient at our office? ☐ Yes ☐ No

## Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ SS #/SIN _____ Date employed _____

Name of employer _____ Work phone _____

Address of employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance company _____ Group # _____ Union or local # _____

Ins. Co. address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Relationship to patient _____

Birthdate _____ SS #/SIN _____ Date employed _____

Name of employer _____ Work phone _____

Address of employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance company _____ Group # _____ Union or local # _____

Ins. Co. address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____ _____

Signature of patient or parent/guardian if minor — Date

# Health History Form

E-mail: Today's Date:

ADA.
American Dental Association
www.ada.org

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: (Last First Middle)
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )
Address: (Mailing address)
City: State: Zip:
Occupation:
Height: Weight: Date of birth: Sex: M F
SS# or Patient ID: Emergency Contact:
Relationship: Home Phone: ( ) Cell Phone: ( )
*Include area codes*

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

| **Do you have any of the following diseases or problems:** *(Check DK if you Don't Know the answer to the question)* | Yes | No | DK |
|---|---|---|---|
| Active Tuberculosis | ☐ | ☐ | ☐ |
| Persistent cough greater than a 3 week duration | ☐ | ☐ | ☐ |
| Cough that produces blood | ☐ | ☐ | ☐ |
| Been exposed to anyone with tuberculosis | ☐ | ☐ | ☐ |

***If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.***

## Dental Information *For the following questions, please mark (X) your responses to the following questions.*

| | Yes | No | DK |
|---|---|---|---|
| Do your gums bleed when you brush or floss? | ☐ | ☐ | ☐ |
| Are your teeth sensitive to cold, hot, sweets or pressure? | ☐ | ☐ | ☐ |
| Does food or floss catch between your teeth? | ☐ | ☐ | ☐ |
| Is your mouth dry? | ☐ | ☐ | ☐ |
| Have you had any periodontal (gum) treatments? | ☐ | ☐ | ☐ |
| Have you ever had orthodontic (braces) treatment? | ☐ | ☐ | ☐ |
| Have you had any problems associated with previous dental treatment? | ☐ | ☐ | ☐ |
| Is your home water supply fluoridated? | ☐ | ☐ | ☐ |
| Do you drink bottled or filtered water? | ☐ | ☐ | ☐ |
| If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY | | | |
| Are you currently experiencing dental pain or discomfort? | ☐ | ☐ | ☐ |

What is the reason for your dental visit today?

How do you feel about your smile?

| | Yes | No | DK |
|---|---|---|---|
| Do you have earaches or neck pains? | ☐ | ☐ | ☐ |
| Do you have any clicking, popping or discomfort in the jaw? | ☐ | ☐ | ☐ |
| Do you brux or grind your teeth? | ☐ | ☐ | ☐ |
| Do you have sores or ulcers in your mouth? | ☐ | ☐ | ☐ |
| Do you wear dentures or partials? | ☐ | ☐ | ☐ |
| Do you participate in active recreational activities? | ☐ | ☐ | ☐ |
| Have you ever had a serious injury to your head or mouth? | ☐ | ☐ | ☐ |

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

## Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

| | Yes | No | DK |
|---|---|---|---|
| Are you now under the care of a physician? | ☐ | ☐ | ☐ |
| Physician Name: Phone: *Include area code* ( ) | | | |
| Address/City/State/Zip: | | | |
| Are you in good health? | ☐ | ☐ | ☐ |
| Has there been any change in your general health within the past year? | ☐ | ☐ | ☐ |
| If yes, what condition is being treated? | | | |
| Date of last physical exam: | | | |

| | Yes | No | DK |
|---|---|---|---|
| Have you had a serious illness, operation or been hospitalized in the past 5 years? | ☐ | ☐ | ☐ |
| If yes, what was the illness or problem? | | | |
| Are you taking or have you recently taken any prescription or over the counter medicine(s)? | ☐ | ☐ | ☐ |
| If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: | | | |

# Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

| *(Check DK if you Don't Know the answer to the question)* | Yes | No | DK |
|---|---|---|---|
| Do you wear contact lenses? | | | |
| Are you taking, or have you taken, any diet drugs such as Pondimin (fenfllluramine), Redux (dexphenfluramine) or phen-fen (fenfllluramine-phentermine combination)? | | | |
| Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel™) for osteoporosis or Paget's disease? | | | |
| Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? | | | |
| Date Treatment began: _____ | | | |

| | Yes | No | DK |
|---|---|---|---|
| Do you use controlled substances (drugs)? | | | |
| Do you use tobacco (smoking, snuff, chew, bidis)? | | | |
| If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED | | | |
| Do you drink alcoholic beverages? | | | |
| If yes, how much alcohol did you drink in the last 24 hours? _____ | | | |
| If yes, how much do you typically drink in a week? _____ | | | |
| **WOMEN ONLY** Are you: | | | |
| Pregnant? | | | |
| Number of weeks: _____ | | | |
| Taking birth control pills or hormonal replacement? | | | |
| Nursing? | | | |

**Joint Replacement.** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐
Date: _____ If yes, have you had any complications?

| **Allergies** - Are you allergic to or have you had a reaction to: To all **yes** responses, specify type of reaction. | Yes | No | DK |
|---|---|---|---|
| Local anesthetics | | | |
| Aspirin | | | |
| Penicillin or other antibiotics | | | |
| Barbiturates, sedatives, or sleeping pills | | | |
| Sulfa drugs | | | |
| Codeine or other narcotics | | | |
| Metals | | | |
| Latex (rubber) | | | |
| Iodine | | | |
| Hay fever/seasonal | | | |
| Animals | | | |
| Food | | | |
| Other | | | |

*Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

| | Yes | No | DK |
|---|---|---|---|
| Heart murmur | | | |
| Mitral valve prolapse | | | |
| Artificial heart valves | | | |
| Rheumatic fever | | | |
| Cardiovascular disease | | | |
| Angina | | | |
| Arteriosclerosis | | | |
| Congestive heart failure | | | |
| Coronary artery disease | | | |
| Damaged heart valves | | | |
| Heart attack | | | |
| Low blood pressure | | | |
| High blood pressure | | | |
| Congenital heart defects | | | |
| Pacemaker | | | |
| Rheumatic heart disease | | | |
| Abnormal bleeding | | | |
| Anemia | | | |
| Blood transfusion | | | |
| If yes, date: _____ | | | |
| Hemophilia | | | |
| AIDS or HIV infection | | | |
| Arthritis | | | |
| Autoimmune disease | | | |
| Rheumatoid arthritis | | | |
| Systemic lupus erythematosus | | | |
| Asthma | | | |
| Bronchitis | | | |
| Emphysema | | | |
| Sinus trouble | | | |
| Tuberculosis | | | |
| Cancer/Chemotherapy/ Radiation Treatment | | | |
| Chest pain upon exertion | | | |
| Chronic pain | | | |
| Diabetes Type I or II | | | |
| Eating disorder | | | |
| Malnutrition | | | |
| Gastrointestinal disease | | | |
| G.E. Reflux/persistent heartburn | | | |
| Ulcers | | | |
| Thyroid problems | | | |
| Stroke | | | |
| Glaucoma | | | |
| Hepatitis, jaundice or liver disease | | | |
| Epilepsy | | | |
| Fainting spells or seizures | | | |
| Neurological disorders | | | |
| If yes, Specify: _____ | | | |
| Sleep disorder | | | |
| Mental health disorders | | | |
| Specify: _____ | | | |
| Recurrent Infections | | | |
| Type of infection: _____ | | | |
| Kidney problems | | | |
| Night sweats | | | |
| Osteoporosis | | | |
| Persistent swollen glands in neck | | | |
| Severe headaches/ migraines | | | |
| Severe or rapid weight loss | | | |
| Sexually transmitted disease | | | |
| Excessive urination | | | |

Have you been told that you snore? Yes / No / Not sure
Have you ever woken up gasping for air? Yes / No Not sure

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: Phone:

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

**NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

## FOR COMPLETION BY DENTIST

Comments: _____

**Dr. Anthony T. Dioguardi**
**Crown Tower – 123 York Street**
**New Haven, CT 06511**

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

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

_____

_____

_____

# SLEEP SCREENING QUESTIONNAIRE

DATE:_____

NAME:_____

DATE OF BIRTH:_____AGE:_____

STREET ADDRESS:_____

CITY/STATE/ZIP:_____

HOME PHONE:_____BUSINESS:_____CELL:_____

SLEEP PHYSICIAN and LOCATION:_____

PRIMARY CARE PHYSICIAN and LOCATION:_____

REFERRED BY:_____

SPECIALIST (Cardiologist, ENT, Neurologist):_____

DENTIST and LOCATION_____

MEDICAL INSURANCE COMPANY:_____

SECONDARY MEDICAL INSURANCE COMPANY:_____

HEIGHT_____WEIGHT_____

What are the chief complaints for which you are seeking treatment?

*Please check all that apply*

- ☐ Frequent heavy snoring
- ☐ Snoring that affects the sleep of others
- ☐ Significant daytime sleepiness that interferes with daily activity
- ☐ I have been told that "I stop breathing" while sleeping
- ☐ Insomnia
- ☐ Waking up gasping for air
- ☐ Inappropriate daytime napping (during conversation, driving, eating etc.)
- ☐ Feeling unrefreshed in the morning
- ☐ Morning headaches
- ☐ Morning hoarseness
- ☐ Involuntary limb movements in sleep
- ☐ Nocturnal teeth grinding
- ☐ Jaw pain
- ☐ Facial pain
- ☐ Jaw clicking

_____ _____

Patient Signature Date

## THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

| **Check one in each row:** | 0<br>No chance of dozing | 1<br>Slight chance of dozing | 2<br>Moderate chance of dozing | 3<br>High chance of dozing |
|---|---|---|---|---|
| Sitting and reading | ☐ | ☐ | ☐ | ☐ |
| Watching TV | ☐ | ☐ | ☐ | ☐ |
| Sitting inactive in a public place (e.g. a theater or a meeting) | ☐ | ☐ | ☐ | ☐ |
| As a passenger in a car for an hour without a break | ☐ | ☐ | ☐ | ☐ |
| Lying down to rest in the afternoon when circumstances permit | ☐ | ☐ | ☐ | ☐ |
| Sitting and talking to someone | ☐ | ☐ | ☐ | ☐ |
| Sitting quietly after lunch without alcohol | ☐ | ☐ | ☐ | ☐ |
| In a car, while stopped for a few minutes in traffic | ☐ | ☐ | ☐ | ☐ |

Patient Signature _____ Date _____

## SLEEP CENTER EVALUATION

Have you ever had an evaluation at a sleep center ☐ Yes ☐ No

If Yes:

Sleep center name:_____

Location:_____Sleep study date:_____

## AFFIDAVIT FOR INTOLERANCE OR NONCOMPLIANCE TO CPAP

I,_____, have attempted to use a CPAP (Continuous Positive Air Pressure) to manage my sleep-related breathing disorder (OSA-Obstructive Sleep Apnea) and find it intolerable to use on a regular basis for the following reason(s):

- ☐ Mask leaks
- ☐ An inability to get the mask to fit properly
- ☐ Discomfort caused by the straps and headgear
- ☐ Disturbed or interrupted sleep caused by the presence of the device
- ☐ Noise from the device disturbing my sleep and/or bed partner's sleep
- ☐ CPAP restricted movements during sleep
- ☐ CPAP does not seem to be effective
- ☐ Pressure on the upper lip causing tooth related problems
- ☐ Latex allergy
- ☐ Claustrophobic
- ☐ An unconscious need to remove the CPAP in the night
- ☐ Other_____

Was CPAP therapy attempted for 45 days or more? _____

**WAS CPAP RETURNED TO SUPPLIER?** _____

Because of my intolerance/inability to use a CPAP, I wish to have my OSA treated by Oral Appliance Therapy utilizing a custom fitted Mandibular Advancement Device.

_____

Patient Signature Date

## OTHER THERAPIES OR ATTEMPTS

Please list any other therapies or attempts you may have tried for breathing/sleep disorders:
(E.g. surgery, quitting smoking, weight-loss attempts, other oral appliances, etc.)

_____

# HISTORY

*Please check the option that best applies:*

| | Never | Once per week | Several days per week | Daily |
|---|---|---|---|---|
| How often do you consume alcohol within 2-3 hours of bedtime? | ☐ | ☐ | ☐ | ☐ |
| How often do you take sedatives within 2-3 hours of bedtime? | ☐ | ☐ | ☐ | ☐ |
| How often do you consume caffeine within 2-3 hours of bedtime? | ☐ | ☐ | ☐ | ☐ |

| | Never | Occasionally | Daily | Number of cigarettes per day |
|---|---|---|---|---|
| Do you use tobacco (smoking, snuff or chew)? | ☐ | ☐ | ☐ | _____ |

*Please check if any members of your family have had:*

- ☐ Heart disease
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Diagnosed or treated for a sleep disorder

_____ _____

Patient Signature Date

# BERLIN QUESTIONNAIRE
# SLEEP EVALUATION

1. Please complete the following:

Height_____Weight_____

Age_____Male/Female____

2. Do you snore?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

*If you snore:*

3. Your snoring is:
   - ☐ Slightly louder than breathing
   - ☐ As loud as talking
   - ☐ Louder than talking
   - ☐ Very loud (can be heard in Adjacent rooms)

4. How often do you snore?
   - ☐ Nearly every day
   - ☐ 3-4 times per week
   - ☐ 1-2 times per week
   - ☐ 1-2 times per month
   - ☐ Never or nearly never

5. Has your snoring ever bothered other people?
   - ☐ Yes
   - ☐ No

6. Has anyone noticed that you quit breathing during your sleep?
   - ☐ Nearly every day
   - ☐ 3-4 times per week
   - ☐ 1-2 times per week
   - ☐ 1-2 times per month
   - ☐ Never or nearly never

7. How often do you feel tired or fatigued after your sleep?
   - ☐ Nearly every day
   - ☐ 3-4 times per week
   - ☐ 1-2 times per week
   - ☐ 1-2 times per month
   - ☐ Never or nearly never

8. During your wake time, do you feel tired, fatigued or not up to par?
   - ☐ Nearly every day
   - ☐ 3-4 times per week
   - ☐ 1-2 times per week
   - ☐ 1-2 times per month
   - ☐ Never or nearly never

9. Have you ever nodded off or fallen asleep while driving a vehicle?
   - ☐ Yes
   - ☐ No

*If yes, how often does it occur?*
   - ☐ Nearly every day
   - ☐ 3-4 times per week
   - ☐ 1-2 times per week
   - ☐ 1-2 times per month
   - ☐ Never or nearly never

10. Do you have high blood pressure?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know

_____ Patient Signature

_____ Date

**Anthony T. Dioguardi, D.M.D.**
**123 York Street**
**New Haven, CT 06511**
**Tel: (203) 777-2513**
**Fax: (203) 776-1714**
**Email: dental123york@gmail.com**

# MEDICAL/DENTAL INFORMATION AUTHORIZATION

I, _____, authorize the release of copies of all medical/dental records, including documents pertaining to treatment and history, radiographs, photographs, and models **from**:

Dentist/Physician/Provider_____
Address_____
Telephone #_____
Fax#_____

Please send all of the requested information **to**:

Dentist/Physician/Provider_____
Address_____
Telephone #_____
Fax#_____

I also authorize the use of a photographic or facsimile reproduction of this release to have the full force and effect of the original.

_____ _____
Patient Date

# Notice of Privacy Practices

**Purpose:** This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. (Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.)

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

# 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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

## OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 1/1/2005, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

## USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

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

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**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 of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

## PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.75 for each page, $20 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**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.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

## 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 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 Officer: DR. ANTHONY DIOGUARDI

Telephone: 203 777 2513 Fax: 203 776 1714

E-mail: dental123york@gmail.com

Address: 123 YORK STREET, NEW HAVEN, CT, 06511

**Dr. Anthony Dioguardi**
Towers Medical Center
123 York Street, Suite 2J
New Haven, CT 06511
(203) 777-2513

# DIRECTIONS TO OUR OFFICE

GPS:

**If you choose to use your GPS, set the address to 347 George St., New Haven, CT and it should take you to the entrance of our attended parking garage.**

The entrance to our parking garage (sign marked **CROWN TOWER/ TOWERS MEDICAL CENTER**) is 1/2 block on the left side of George Street between York and High Streets, opposite the Frontier building.

From I-95 North

Take I-95 N to **exit 47 (Route 34 exit)**;
After you exit, make your way to the right lane. Continue straight on North Frontage Rd. staying in the right lane (NOT THE TURNING LANE)
Take a **right** on to **York Street**;
Proceed one block to the next traffic light and make a **right** on to **George Street;**
The entrance to our parking garage (sign marked **CROWN TOWER/TOWERS MEDICAL CENTER**) is 1/2 block on the left side of George Street between York and High Streets, opposite the Frontier building.

From Derby Ave. or the Merritt Parkway:

**Route 34** past the Yale Bowl; through Boulevard intersection; road **becomes Derby Ave.**; then **becomes George Street**. Continue on **George Street** into New Haven.
The entrance to our parking garage (sign marked **CROWN TOWER/TOWERS MEDICAL CENTER**) on the left side of George Street between York and High Streets, opposite the Frontier building.

From I-91

Take **I-91S** to **Exit 1 (Route 34 exit)**;
Continue straight on North Frontage Rd. staying in the right lane (NOT THE TURNING LANE)
Take a **right** on to **York Street**;
Proceed one block to the next traffic light and make a **right** on to **George Street;**
The entrance to our parking garage (sign marked **CROWN TOWER/TOWERS MEDICAL CENTER**) is 1/2 block on the left side of George Street between York and High Streets, opposite the Fronter building.

From Whitney Avenue:

Take **Whitney Avenue;** road **becomes Temple Street; continue** past the New Haven Green and Temple Medical Building and proceed straight until road bends to right and merges with **North Frontage Road.**
**Stay in the right lane** and continue straight on North Frontage Road.
Proceed two blocks to second traffic light and make a **right** on to **York Street.**
Proceed one block to the next traffic light and make a **right** on to **George Street;**
The entrance to our parking garage (sign marked **CROWN TOWER/TOWERS MEDICAL CENTER**) is 1/2 block on the left side of George Street between York and High Streets, opposite the Frontier building.

******Our attended parking garage charges a $2 fee to park.***