



Welcome to our practice

Name: _____ Date of birth: _____
(Last) (first) (MI)

Preferred name: _____

Address: _____
Street City State Zip Code

Home Phone #: _____ Work #: _____ Cell #: _____

Email address: _____ Best way to reach you: _____

Gender: Male Female

Reason for appointment (preventative, pain, concerns): _____

Referral information

Whom can we thank for referring you to our practice? How did you hear about us? _____

Insurance

Insurance company: _____ Policyholder's Name: _____

Policyholder's date of birth : _____ Patient relationship to policyholder: _____

Policyholder's ID: _____ Insurance Phone #: _____

Group/employer name: _____ Group number: _____

Dental history

How long has it been since you last saw a dentist? _____

Patient Medical History

Patient Name:

Birth Date:

Date Created:

Have you ever been hospitalized or had a major operation? Yes No If yes _____

Have you ever had a serious head or neck injury? Yes No If yes _____

Are you taking any prescription medications? Yes No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes _____

Do you use tobacco? Yes No

Women: Are you...

Pregnant/Trying to get pregnant?

Nursing?

Taking oral contraceptives?

Do you have allergies to any medications or foods? Yes No If yes _____

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

- | | | | |
|--|---|---|--|
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No | Anemia <input type="radio"/> Yes <input type="radio"/> No |
| Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No | Angina <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No |
| Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Athritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No | Artificial Joint <input type="radio"/> Yes <input type="radio"/> No |
| Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No | Breathing Problems <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No |
| Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Cancer <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Chemotherapy <input type="radio"/> Yes <input type="radio"/> No |
| Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No |
| Diabetes <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No |
| Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No |
| Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Asthma <input type="radio"/> Yes <input type="radio"/> No | Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Bruise Easily <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above? Yes No If yes _____

Comments:

Empty text box for patient comments.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____



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 10/01/2007, 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

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 \$25.00 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 CONCERNS

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.

Telephone: (978) 468-7746

Fax: (978) 468-2146

E-Mail: office@greenwillowdental.com

Business Address: 205 Willow Street, Suite B, South Hamilton, MA 01982



Acknowledgement of receipt of notice of privacy practices*

I, _____ Date of birth _____
(print name)

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

Signed: _____

Signed: _____
(parent, legal guardian, or POA of the patient, if patient is unable to sign themselves)

Date: _____

**You may refuse to sign this acknowledgement.*

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.



Informed consent for general dental procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with our dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre- and post-treatment instructions, referrals to other dentists or specialists, and return for schedule appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

Treatment to be provided

I understand that during my course of treatment that the following care may be provided: (Initials)

- Examinations
- Preventative services
- Restorations
- Crowns
- Bridges
- Other

Drugs and medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). (Initials)

Changes in treatment plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. (Initials)

I give permission to the dental office to bill my dental insurance provider for the treatment provided. (Initials)

Signed: _____

Signed: _____
(parent, legal guardian, or POA of the patient, if patient is unable to sign themselves)

Date: _____

Office Financial Policy

We try to make your dental care as cost-efficient as possible. One measure we have taken to keep costs down is to minimize our billing and accounting; therefore, we ask for payment at the time of service. Financial arrangements must be established before our office can proceed with any recommended treatment.

All patients who are seen in our office for a comprehensive exam are provided with a treatment plan. This is an estimate of the anticipated cost of your dental treatment. Your treatment plan will include an estimated insurance payment based on your dental coverage. If your carrier's payment differs from our estimate, you are responsible for the balance. In the case of overpayment, you are entitled to a prompt refund. Any claims over 90 days become your responsibility.

In cases of divorce or separation, the parent bringing the child is responsible for payment.

Cancellation Policy

If it becomes necessary to reschedule your appointment, we request the courtesy of 24 hours' notice. If you cancel, do not show, or miss your appointment without the required notice, we will assess a **broken appointment fee of \$85.00 for cleanings and \$109.00 for appointments with the dentist.** These fees are strictly enforced and will not be covered by your insurance.

If you have any questions regarding your account balance, or if you are experiencing circumstances beyond your control, please contact our office. We will be happy to assist you with your questions or to set up special payment arrangements.

Our practice firmly believes that a good doctor/patient relationship is based upon a clear understanding of office policies and an open line of communication. We have instructed our staff to make every effort to clarify any misunderstandings you may have concerning your account balance or our financial policies. We hope to avoid any possible disagreements over payment for professional services.

Our patients and our relationships with our patients are very important to us. If you have any questions or need assistance, please contact us immediately.

Signed: _____

Signed: _____
(parent, legal guardian, or POA of the patient, if patient is unable to sign themselves)

Date: _____