PATIENT INFORMATION

Patient # _____
SS# _____
Date _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ Cell Phone _____

Email _____ State _____ Zip _____

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

If student, name of school _____ City _____ State _____ ☐ Full-time ☐ Part-time

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

Employer address _____ City _____ State _____ Zip _____

Spouse/Parent/Guardian's name _____ Employer _____ Work phone _____

Emergency contact _____ Phone _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship _____

Address _____ Home phone _____ Cell Phone _____

Email _____ Birthdate _____ State _____ Zip _____

Are you currently a patient in our office? ☐ Yes ☐ No Driver's license # _____

Employer _____ Work phone _____ SSN _____

We offer the following methods of payment. Please check the option you prefer.

☐ Cash ☐ Personal Check ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy

INSURANCE INFORMATION

Name of insured _____ Relationship to patient _____

Birthdate _____ SSN _____ Date employed _____

Name of employer _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance _____ Group# _____ Policy/ID# _____

Insurance address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No If **YES**, complete the following:

Insurance _____ Group# _____ Policy/ID# _____

Thank you for selecting our dental healthcare team! If you have any questions or need assistance, please ask us - we will be happy to help.

Who may we thank for referring you? _____

MEDICAL HISTORY

Patient # _____

SS# _____

Date _____

Physician _____ Office Phone _____ Date of last exam _____

Are you under medical treatment now? ☐ Yes ☐ No

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ☐ Yes ☐ No
If yes, please explain: _____

Are you any medication(s), including non-prescription? ☐ Yes ☐ No
If yes, please explain: _____

Have you ever taken Fen-Phen/Redux? ☐ Yes ☐ No

Have you ever taken any cancer medications? ☐ Yes ☐ No

Have you taken Viagra, Cialis, or Levitra in the last 24 hours? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Are you allergic to or have reactions to the following:

- Local Anesthetics (e.g. Novocaine) ☐ Yes ☐ No
- Penicillin or Antibiotics ☐ Yes ☐ No
- Sulfa Drugs ☐ Yes ☐ No
- Barbiturates ☐ Yes ☐ No
- Sedatives ☐ Yes ☐ No
- Iodine ☐ Yes ☐ No
- Aspirin ☐ Yes ☐ No
- Any Metals (e.g. nickel, mercury, etc.) ☐ Yes ☐ No
- Latex Rubber ☐ Yes ☐ No
- Other (please list) ☐ Yes ☐ No

Do you have a persistent cough or throat clearing not associated with common illness? ☐ Yes ☐ No

Are you pregnant or think you may be pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Are you taking oral contraceptives? ☐ Yes ☐ No

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

- High Blood Pressure ☐ Yes ☐ No
- Heart Attack ☐ Yes ☐ No
- Rheumatic Fever ☐ Yes ☐ No
- Swollen Ankles ☐ Yes ☐ No
- Fainting/Seizures ☐ Yes ☐ No
- Asthma ☐ Yes ☐ No
- Low Blood Pressure ☐ Yes ☐ No
- Epilepsy/Convulsions ☐ Yes ☐ No
- Leukemia ☐ Yes ☐ No
- Diabetes ☐ Yes ☐ No
- Kidney Disease ☐ Yes ☐ No
- AIDS or HIV Infection ☐ Yes ☐ No
- Thyroid Problem ☐ Yes ☐ No
- Heart Disease ☐ Yes ☐ No
- Cardiac Pacemaker ☐ Yes ☐ No
- Heart Murmur ☐ Yes ☐ No
- Angina ☐ Yes ☐ No
- Frequently Tired ☐ Yes ☐ No
- Anemia ☐ Yes ☐ No
- Emphysema ☐ Yes ☐ No
- Cancer ☐ Yes ☐ No
- Arthritis ☐ Yes ☐ No
- Joint Replacement/Implant ☐ Yes ☐ No
- Hepatitis/Jaundice ☐ Yes ☐ No
- STD ☐ Yes ☐ No
- Stomach Trouble/Ulcer ☐ Yes ☐ No
- Chest Pains ☐ Yes ☐ No
- Hay Fever Allergies ☐ Yes ☐ No
- Stroke ☐ Yes ☐ No
- Tuberculosis ☐ Yes ☐ No
- Radiation Therapy ☐ Yes ☐ No
- Glaucoma ☐ Yes ☐ No
- Recent Weight Loss ☐ Yes ☐ No
- Liver Disease ☐ Yes ☐ No
- Heart Trouble ☐ Yes ☐ No
- Respiratory Problems ☐ Yes ☐ No
- Mitral Valve Prolapse ☐ Yes ☐ No
- Other ☐ Yes ☐ No

DENTAL HISTORY

Previous dentist & location _____ Date of last exam _____

Do your gums bleed while brushing or flossing? ☐ Yes ☐ No

Are your teeth sensitive to hot or cold? ☐ Yes ☐ No

Are your teeth sensitive to sweet or sour? ☐ Yes ☐ No

Do you feel pain to any of your teeth? ☐ Yes ☐ No

Do you have any sores or lumps in or near your mouth? ☐ Yes ☐ No

Have you had any head, neck, or jaw injuries? ☐ Yes ☐ No

Have you ever experienced any of the following:

- Jaw clicking ☐ Yes ☐ No
- Pain (jaw, joint, ear, side of face) ☐ Yes ☐ No
- Difficulty opening or closing jaw ☐ Yes ☐ No
- Difficulty chewing ☐ Yes ☐ No

Do you have frequent headaches? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you bite your lips or cheeks frequently? ☐ Yes ☐ No

Have you had difficult extractions in the past? ☐ Yes ☐ No

Have you had prolonged bleeding after extractions? ☐ Yes ☐ No

Have you had any orthodontic treatment? ☐ Yes ☐ No

Do you wear dentures or partials? ☐ Yes ☐ No

If yes, date of placement: _____

Have you ever received oral hygiene instructions regarding the care of your teeth and/or gums? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

AUTHORIZATION & RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X _____ Date _____

Signature of patient (or parent/guardian if a minor)

FINANCIAL POLICIES FORM

Thank you for choosing Cordial Dental as your dental provider, we would strive our best efforts to achieve best dental care for you, your family and friends.

Payment is expected the day services are rendered. For patients with dental insurance, if you provide the office with your dental insurance information, we will contact your insurance company and verify your benefits. We will do our very best to answer any questions you may have about your insurance coverage but always suggest that you contact them directly whenever possible.

As a courtesy to you, we will gladly submit the insurance claim to your insurance company on the day of service. We will collect the estimated copayment and deductible at each visit. We make every effort to determine your insurance benefits when you receive treatment, but consider your co-payment an **estimate** until we receive payment from your insurance company. Please remember that any information we provide relative to your insurance coverage is our best **estimate** and not a guarantee of the payment that will be received.

In order to provide quality dental care in a timely manner, we have a cancellation and no show policy. The policy enables us to better utilize available appointments for our patients in need of dental care.

CANCELLATION OF AN APPOINTMENT

In order to be respectful of other patient's needs, please be courteous and call our office promptly if you are unable to keep your appointment. This time will be given to someone who is in urgent need of treatment. We ask that you notify us 48 business hours in advance, in order to cancel or reschedule any appointments.

I have read and understand the appointment policy at Boston Dental. I have also read and understand the billing procedures at Boston Dental. I agree to be responsible for full payment of all charges for dental services performed on me. If for any reason the insurance does not pay its estimated portion, I agree that I will be responsible for the account balance. In the event that my account is placed with a third party collection agency or attorney, I will be assessed any fees relating to this action.

Please print name_____

Signature _____

Date_____

GENERAL CONSENT FOR TREATMENT

I, the undersigned, hereby authorize my doctor(s) to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my determined needs. I understand that x-rays are required on a yearly basis for accurate diagnoses. I understand that the use of anesthetic agents embodies a certain risk and I acknowledge that I have provided a thorough and honest report of my medical and dental history.

I understand that any treatment plans presented along with fees outlines, could change depending on the time elapsed since the initial examination and extent of dental pathology. Occasionally once the treatment plan has been started, complications may arise that dictate additional procedures or treatment. The doctors or their staff will always advise me of any changes. I understand that there is no guarantee to the outcome of any services performed.

PERIODONTAL MAINTENANCE

Periodontal maintenance is always scheduled following scaling and root planning. Please be aware that there may be a patient co payment for this service.

Please print name

_____

Signature

_____

Date

_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Please print name

_____

Signature

_____

Date

_____

For office use only:

- # *Individual refused to sign*
- # *Communication barriers prohibited obtaining the acknowledgment*
- # *An emergency prevented us from obtaining acknowledgment*
- # *Other (please specify)* _____

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

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.

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.

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.__ for each page, $__ 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.

SUBMIT FORM
