Today's Date_____

Patient Name _____ Date of Birth _____

Street_____ City _____ Zip _____

Home Phone ( )_____ Employer _____

Work Phone ( )_____ Occupation _____

Cell Phone ( )_____ Soc. Sec. # _____

Emergency Contact # _____

INSURANCE INFORMATION

Dental Insurance_____ Subscriber _____ DOB _____

Subscriber's I.D.#_____ Employer _____

Group # _____ *If college student; name & address of college _____

I the undersigned, give permission for treatment and I understand I am personally responsible for any amount that insurance does not cover; quotes from my insurance company is not a guarantee of benefits and my estimated co-payment is due at the time treatmen is completed. I understand if my insurance company does not pay the practice within a reasonable length of time (45 days) I will be billed for payment.

Signature X_____

History of:		
Tuberculosis	Yes	No
Cancer	Yes	No
Radiation	Yes	No
Heart Problems *(coronary, angina, murmur heart or valve surgery)*	Yes	No
Pacemaker	Yes	No
Rheumatic Fever	Yes	No
High Blood Preasure	Yes	No
Low Blood Preasure	Yes	No
Bleeding Tendencies/Disorders	Yes	No
Anemia	Yes	No
Diabetes	Yes	No
Hepatisis - Type_____ *(if yes, late date tested negative)* _____	Yes	No
Emphysema	Yes	No
Asthma/Reperatory Problems	Yes	No
Ulcers	Yes	No
Kidney Problems	Yes	No
Liver Problems	Yes	No
Thyroid Problems	Yes	No
Sinus Problems	Yes	No
Venereal Disease	Yes	No
HIV	Yes	No
AIDS	Yes	No
Glaucoma	Yes	No
Epilepsy or Seizures	Yes	No
Plate, Pins. Screws, or Artificial Joints	Yes	No

Medical History:		
Do you smoke/chew tobacco?	Yes	No
Have you had any recent surgery?	Yes	No
Are you taking steroids?	Yes	No
Are you allergic to any of the following:		
Penicillin	Yes	No
Aspirin	Yes	No
Codeine	Yes	No
Local Anesthesia *(novacaine)*	Yes	No
Other Medications	Yes	No
Latex	Yes	No
Other Allergies	Yes	No

_____

_____

Do you have any medical problems not listed above?

_____

_____

Please list any medications you are taking *(including birth control or aspirin)* _____

_____

Your Physicians name, address, & phone number:

_____

_____

Women: Are you pregnant? Yes No

Who should we thank for referring you to us? _____

Policies for South Boston Dental Assoc.

In an effort to avoid any misunderstanding, we would like to review our financial and office policies before you begin treatment in our office. Standard of care in this practice requires full mouth x-rays every 5 years, bitewings and exam every year. We will not treat patients without updated x-rays.

Payment is expected at the time services are performed. We accept MasterCard, and Visa. For extensive services we offer low and **no interest** payment plans through Care Credit.

For our patients with dental insurance our policy is as follows:

You will need to supply us with the subscriber's information (name, date of birth, social security number, employer and ID#) as well as the name and address of the insurance company. We will do our best to answer any questions you may have about your insurance coverage but we always suggest that you call or visit your insurance company's web site.

As a courtesy to our patients, we will gladly submit the insurance claim to your insurance company. We will collect your **estimated** co payment 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.

Appointment policy

We reserve appointment times specifically for each patient so that we may provide the ultimate service. Please schedule your appointment carefully as there will be a charge to your account for any appointment cancelled without a 24 hour notice. Similarly, late arrivals can create scheduling problems with other patients. Please notify us if you are going to be late.

If you have any questions about any of our policies, please feel free to ask any member of our staff.

Signature_____ Date___

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist or hygienist. 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 your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, not 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 scheduled 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.

1. **Treatment to be Provided**

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

Examinations Preventative Services Restorations Crowns Bridges Other

Patients Initials_____

2. **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). I understand that delivery of local anesthesia may result in (but not limited to) cardiovascular response; anaphylactic reaction, or parasthesia. Patients' initials _____

3. **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. If this occurs we will inform you of the change before treatment is completed. Patients Initials _____

4. I give my permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. Patient Initials _____

Patient Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected Dental health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple Dental healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal Dental healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my Dental health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or Dental healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name_____
Relationship to Patient_____
Signature_____
Date_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date_____
Initials_____
Reason_____

ASSIGNMENT OF INSURANCE BENEFITS

I DO HEREBY AUTHORIZE PAYMENT OF DENTAL BENEFITS DIRECTLY TO SOUTH BOSTON DENTAL ASSOCIATES, INC., 29 FARRAGUT ROAD, SOUTH BOSTON, MASSACHUSETTS 02127.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THE ASSIGNMENT.

DATE_____**SIGNATURE**_____

AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE ANY INFORMATION TO BE RELEASED TO THE INSURANCE COMPANY FOR PROCESSING THIS CLAIM.

DATE_____**SIGNATURE**_____

South Boston Dental Associates, Inc.
29 Farragut Road
South Boston, Massachusetts 02127
Tel: (617) 268-1030/Fax: (617) 268-2924

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.
As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your dental health information.
We may use and disclose your dental records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing dental health care and related services by one or more dental health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Dental Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be internal quality assessment review.

We may also create and distribute de-identified dental health information by removing all references to individually identifiable information.
We may contact you to provide appointment reminders or information about treatment alternatives or other dental health-related benefits and services that may be of interest to you.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already take actions relying on your authorization.
You have the following rights with respect to your protected dental health information, which you can exercise by presenting a written request to the Practice Administrator.

- The right to request restrictions on certain uses and disclosures of protected dental health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected dental health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected dental health information.
- The right to amend your protected dental health information.
- The right to receive an accounting of disclosures of protected dental health information.
- The right to obtain a paper copy of this notice from us upon request.