# PATIENT INFORMATION

Patient Name _____ Sex: M / F Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Patient/Parent Cell Phone _____ Work Phone _____

Email _____ Check Appropriate ___ Minor ___ Single ___ Married ___Divorced ___Widowed ___ Separated

If Student, Name of School/College _____ City _____ State _____ Full Time ___ Part Time ___

## Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ Email _____

Employer _____ City/State _____ Birthdate _____ SS# _____

Is this Person Currently a Patient in Our Office? ___ Yes ___ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. **Payment in full at each appointment.**
___Cash ___ Personal Check ___ VISA ___ Master Card ___ Care Credit

Spouse or Parent/Guardian Name_____ Employer_____ Work Phone_____

Cell Phone _____ SS# _____ Birthdate _____

Person to Contact in Case of Emergency _____ Phone _____ Whom May We Thank For Referring You? _____

Parents Marital Status ___ Single ___ Married ___Divorced ___Widowed ___ Separated

## Insurance Information (PLEASE PROVIDE OFFICE WITH COPY OF INSURANCE CARD)

Name of Insured _____ Relationship to Patient _____ Insured SS# or ID _____

Date of Birth _____ Employer _____ Work Phone _____ Cell Phone _____

Address of Employer _____ City_____ State_____ Zip_____

Insurance Company _____ Group Number _____ Policy ID _____ Insurance Co. Phone # _____

Insurance Address _____

**DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ___ YES ___ NO**

Name of Insured _____ Relationship to Patient _____ Insured SS # or ID _____

Date of Birth _____ Employer_____ Insurance Company _____ Phone Number _____

Group Number _____ Policy ID _____ Insurance Address _____

## Authorization and 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 dependents. 24 hour notice required for cancellations to avoid a charge.**

X_____ Date_____
Signature of patient (or parent/guardian if minor)

# HEALTH HISTORY

Physician's Name_____ Phone Number_____ Date of Last Visit_____

Do you take any Bisphosphat medications such as Fosamax or Actonel Boniva ? ___Yes ___No

**Place a mark on "Yes" or "No" to indicate if you have had any of the following:**

| | | | | | |
|---|---|---|---|---|---|
| AIDS/HIV | ___Yes ___No | Epilepsy | ___Yes ___No | Respiratory Disease | ___Yes ___No |
| Anemia | ___Yes ___No | Fainting or Dizziness | ___Yes ___No | Rheumatic Fever | ___Yes ___No |
| Arthritis, Rheumatism | ___Yes ___No | Glaucoma | ___Yes ___No | Scarlet Fever | ___Yes ___No |
| Artificial Heart Valve | ___Yes ___No | Headaches | ___Yes ___No | Shortness of Breath | ___Yes ___No |
| Artificial Joints | ___Yes ___No | Heart Murmur | ___Yes ___No | Sinus Trouble | ___Yes ___No |
| Asthma | ___Yes ___No | Heart Problems | ___Yes ___No | Skin Rash | ___Yes ___No |
| Back Problems | ___Yes ___No | Hepatitis Type_____ | ___Yes ___No | Special Diet | ___Yes ___No |
| Bleeding abnormally, with | ___Yes ___No | Herpes | ___Yes ___No | Stroke | ___Yes ___No |
| Extractions or Surgery | | High Blood Pressure | ___Yes ___No | Swollen Feet or Ankles | ___Yes ___No |
| Blood Disease | ___Yes ___No | Jaundice | ___Yes ___No | Swollen Neck Glands | ___Yes ___No |
| Cancer | ___Yes ___No | Jaw Pain | ___Yes ___No | Thyroid Problems | ___Yes ___No |
| Chemical Dependency | ___Yes ___No | Kidney Disease | ___Yes ___No | Tonsillitis | ___Yes ___No |
| Chemotherapy | ___Yes ___No | Liver Disease | ___Yes ___No | Tuberculosis | ___Yes ___No |
| Circulatory Problems | ___Yes ___No | Low Blood Pressure | ___Yes ___No | Tumor or growth on | ___Yes ___No |
| Congenital Heart Lesions | ___Yes ___No | Mitral Valve Prolapse | ___Yes ___No | head or neck | |
| Cortisone Treatments | ___Yes ___No | Nervous Problems | ___Yes ___No | Ulcer | ___Yes ___No |
| Cough, persistent or bloody | ___Yes ___No | Pacemaker | ___Yes ___No | Venereal Disease | ___Yes ___No |
| Diabetes | ___Yes ___No | Psychiatric Care | ___Yes ___No | Weight Loss, unexplained | ___Yes ___No |
| Emphysema | ___Yes ___No | Radiation Treatment | ___Yes ___No | Other_____ | ___Yes ___No |

Do you wear contact lenses? ___Yes ___No

**Women:**

Are you pregnant? ___Yes ___No Due Date_____ Are you nursing ___Yes ___No

Taking birth control pills? ___Yes ___No

## MEDICATIONS

List any medications you are currently taking and correlating diagnosis

_____

_____

Pharmacy Name _____

Phone (____) _____

Note: _____

## ALLERGIES

| | |
|---|---|
| ___Yes ___No Aspirin | ___Yes ___No Local Anesthetic |
| ___Yes ___No Penicillin | ___Yes ___No Codeine |
| ___Yes ___No Sulfa | ___Yes ___No Iodine |
| ___Yes ___No Latex | Other_____ |
| ___Yes ___No Barbiturates (Sleeping Pills) | |

## DENTAL INFORMATION

**Place a mark on "Yes" or "No to indicate if you have had any of the following**

Reason for today's visit

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental x-rays _____

How often do you floss? _____

How often do you brush_____

| | | | |
|---|---|---|---|
| Bad breath | ___Yes ___No | Jaw pain or tiredness | ___Yes ___No |
| Bleeding gums | ___Yes ___No | Lip or cheek biting | ___Yes ___No |
| Blisters on lips or mouth | ___Yes ___No | Loose teeth | ___Yes ___No |
| Broken fillings | ___Yes ___No | Mouth breathing | ___Yes ___No |
| Burning sensation on tongue | ___Yes ___No | Mouth Pain, brushing | ___Yes ___No |
| Chew on one side of mouth | ___Yes ___No | Orthodontic treatment | ___Yes ___No |
| Cigarette, pipe, or cigar smoking | ___Yes ___No | Pain around ear | ___Yes ___No |
| Clicking or popping Jaw | ___Yes ___No | Periodontal treatment | ___Yes ___No |
| Dry mouth | ___Yes ___No | Sensitivity to cold | ___Yes ___No |
| Fingernail biting | ___Yes ___No | Sensitivity to heat | ___Yes ___No |
| Food collection between teeth | ___Yes ___No | Sensitivity to sweets | ___Yes ___No |
| Foreign objects | ___Yes ___No | Sensitivity to biting | ___Yes ___No |
| Grinding teeth | ___Yes ___No | Sores or growth in mouth | ___Yes ___No |
| Gums swollen or tender | ___Yes ___No | Other _____ | |

_____


# Our Promise!

Dear Patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA - Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

## So what has changed? Why a privacy policy now? Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

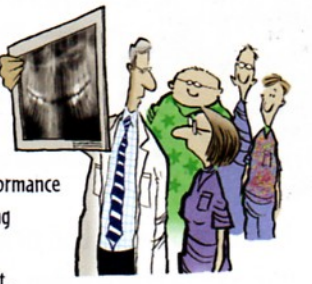

## How your HEALTH INFORMATION may be used

### To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

### To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.



### To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.


### In Patient Reminders

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

**Derry Dental**

7 Peabody Road • Derry, NH 03038 • (603) 434-4962

## Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

## Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or to national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

## For Law Enforcement


As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

## Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

## Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

**Patient Acknowledgment**

Patient Name(s):_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

_____

Patient Signature

Date _____ /_____/_____

# Patient Rights


This new law is careful to describe that you have the following rights related to your health information.

## Restrictions

**You have the right** to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

## Confidential Communications

**You have the right** to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

## Inspect and Copy Your Health Information


**You have the right** to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

## Amend Your Health Information

**You have the right** to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

## Documentation of Health Information

**You have the right** to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

## Request a Paper Copy of this Notice

**You have the right** to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

**You have the right** to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

**#FM-0303** • Printed in U.S.A.

# DERRY DENTAL ASSOCIATES OFFICE POLICIES

**If you have Dental Insurance:**

The office staff will gladly complete the appropriate insurance forms and as a courtesy, will submit the forms to your insurance carrier. Once submitted, your insurance carrier, not our office, determines what they will cover on any dental procedure according to your insurance contract. **Estimated patient co-payments are expected at the time of service unless other arrangements have been discussed.**

**Minors (Under the age of 18) must be accompanied by parent or legal guardian**. In the case that a legal guardian is unable to accompany the minor a written signed consent for treatment is mandatory. We do not give out personal information except to the legal guardians or parents of minors or persons authorized by you below. The office must be notified 24 hours in advance.

**Sharing of Information**

I authorize Derry Dental Associates, or any of its employees to discuss my dental condition and any information pertaining to my dental care with the people I've indicated below. I understand only the people listed below will be given any information regarding my healthcare. **Parents of minors are included unless otherwise informed**.

Name_____ Relationship_____
(i.e. spouse, parent, son, daughter, etc)

Name_____ Relationship_____
(i.e. spouse, parent, son, daughter, etc)

Regarding Patients:_____
I may revoke this authorization at any time by providing written notice to Derry Dental Associates

Signature of Patient_____ Signature of Witness_____

**Cancelled and Broken Appointments:**

**Patients are responsible for all appointments.** However, as a courtesy we may call prior to your appointment as a reminder. We reserve the right to charge for appointments cancelled without a 24 hour advance notice.
There will be a minimum charge of $50.00 for all broken appointments.

**Returned Checks:**

There will be a $20.00 charge for all returned checks. Patients will also be responsible for any additional expenses incurred in processing and collecting delinquent receipts.

All balances over 30 days will be subject to a 1½% monthly service charge.

**Dental Materials Fact Sheet**

I have had the opportunity to review the dental materials fact sheet issued by the FDA in 2002.
A copy is available upon request.
**Initial: _____**

**I have read and understand all the terms mentioned above, and agree to its content.**
**I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to accept responsibility for payment of all services rendered on my behalf, or the behalf of my dependents.**

Signed:_____Date:_____

**INSURANCE AUTHORIZATION-SIGNATURE ON FILE**
I hereby authorized my health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all health benefits due to me and my dependants. I also authorize payment of healthcare benefits otherwise payable to me, directly to my doctor as listed above. I agree to be held responsible for all charges and services not paid by my insurance company,

**WE MUST INSIST THAT ALL PARENTS REMAIN IN THE WAITING ROOM WHEN THEIR CHILD HAS A SCHEDULED VISIT WITH THE DOCTOR.**