COMMUNITY DENTISTS OF WORCESTER

Patient Information Form

PATIENT

Name ______________________ ______________________
Last First

Address ______________________ Apt. # ________

City ______________________ ZIP ________

How long at this address? ______________

Phone ______________ Cell ______________

Email ______________________

Social Security # ______________________

Driver's License # ______________________

Age ________ Date of birth ______________

RESPONSIBLE PARTY (Skip if same as above)

Name ______________________ ______________________
Last First

Address ______________________ Apt. # ________

City ______________________ ZIP ________

How long at this address? ______________

Relationship to patient ______________________

SSN # ______________ Driver's Lic. # ______________

Age ________ Date of birth ______________

EMPLOYMENT

Occupation ______________________

Employer ______________________

Length of employment ______________

Business address ______________________

City ______________________ ZIP ________

Business phone ______________ Ext. ________

EMERGENCY CONTACT

Name ______________________ Phone ______________

HOW DID YOU HEAR ABOUT US?

- ☐ Family/friends
- ☐ Newspaper
- ☐ Radio
- ☐ Office sign
- ☐ Office transfer
- ☐ Yellow Pages
- ☐ Billboard
- ☐ Our website
- ☐ Direct mail
- ☐ Flyer/coupon
- ☐ Online search
- ☐ Online ad
- ☐ Insurance plan
- ☐ TV

Do you have family or friends who may need dental care?
If so, please list name(s) and relationship(s):

____

Were you referred by anyone? ______________

INSURANCE / DENTAL PLAN (primary)

Plan Name ______________________

Address ______________________

City ______________________ ZIP ________

Insurance/Plan Phone # ______________

Insured's name ______________________

Union ________ Group # ________ Plan # ________

Insured's SSN # ______________ Date of birth ______________

INSURANCE / DENTAL PLAN (secondary)

Plan Name ______________________

Address ______________________

City ______________________ ZIP ________

Insurance/Plan Phone # ______________

Insured's name ______________________

Union ________ Group # ________ Plan # ________

Insured's SSN # ______________ Date of birth ______________

1. I certify that the information provided is accurate and will be used to grant credit and provide dental services. I understand that I am financially responsible for all charges not covered by or paid by my insurance for any reason.
2. By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including reports from credit reporting agencies.
3. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges not covered by this authorization. I authorize release of any information relating to any dental claim(s).
4. I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

______________________ ______________
Signature of Patient or Responsible Party Date
(Parent if patient is a minor)

(Please complete both sides)

COMMUNITY DENTISTS OF WORCESTER

Dental History

Date ____________________

Patient name ____________________ (Last) ____________________ (First) Date of birth __________ Age __________

Reason for visit ____________________ Other ____________________

Do you have any health conditions we should be aware of? ☐ Yes ☐ No ____________________

Date of last visit to a dentist ____________________ Treatment performed ____________________

Was the treatment completed? ____________________ When were dental x-rays taken? ____________________

Did you have a cleaning? ☐ Yes ☐ No Have you had periodontal (gum) treatment? ☐ Yes ☐ No

Please check if any of the following apply to you:

☐ Problems with past dental treatment ☐ Bleeding after an extraction ☐ Teeth grinding ☐ Jaw clinching

☐ Ear problems (including popping, locking, pain and clicking) ☐ Temporomandibular Joint Dysfunction (TMJ) Description ____________________

MEDICAL INFORMATION

Are you under a doctor's care? ☐ Yes ☐ No If yes, please specify __________ Dr. name __________ Phone __________

Are you allergic to penicillin, local anesthetics, tranquilizers, codeine or any other medicine? ____________________

Are you currently taking any medications (inc. birth control? (If yes, specify) ____________________

Are you pregnant? If so, how many months? ____________________

Do you have other health problems we should be aware of? ____________________

Please check if you've had any of the following:

☐ Artificial heart valve	☐ Chemo/rad therapy	☐ Heart surgery	☐ Liver problems	☐ Sleep apnea
☐ AIDS/HIV	☐ Cosmetic surgery	☐ Heart problems	☐ Low blood pressure	☐ Smoking tobacco
☐ Anemia	☐ Diabetes	☐ Hepatitis	☐ Lung disease	☐ Stroke
☐ Angina	☐ Dizziness or fainting	☐ High blood pressure	☐ Pacemaker	☐ Thyroid problems
☐ Arthritis	☐ Drug addiction	☐ Jaundice	☐ Phen-fen	☐ TMD or TMJ
☐ Asthma	☐ Epilepsy	☐ Joint replacement	☐ Psychiatric care	☐ Tuberculosis
☐ Bleeding problems	☐ Glaucoma	☐ Kidney disease	☐ Rheumatic fever	☐ Venereal disease
☐ Cancer	☐ Heart attack	☐ Latex allergy	☐ Sinus trouble	

Doctor comments ____________________

I have answered every question completely and accurately to the best of my knowledge. I will inform my dentist of hanges in my health and/or medication. I certify that I consent to taking x-rays and an oral examination.

Signature of Patient or Responsible Party (Parent if patient is a minor) ____________________ Date __________ Signature of doctor ____________________

MEDICAL UPDATE:

Patient signature ____________________ Doctor signature ____________________ Date __________

Patient signature ____________________ Doctor signature ____________________ Date __________

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 or until you discuss potential benefits, risks, and complications with your dentists and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risk 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 specialist, and return for scheduled appointments. If you fail to follow the advice of your dentist, your may increase the chances of a poor outcome.

Please read and initial 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 or Other________

   Patient Initials: ________

2. **Drugs and Medications**

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

   Patient 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 procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

   Patient Initials: ________

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

______________________________ ______________________________

Patient Signature **Date**

COMMUNITY DENTISTS OF WORCESTER

Written Financial Policy

Thank you for choosing Community Dentists of Worcester. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

- Cash, Check, Visa, Master Card, American Express, Discover Card, Care Credit[1] or Lending Club[1]
- Perfect Dental Payment Plan[2]
  - Available for Treatment Plans over $500
  - Automatic weekly/monthly billing to your credit/debit card
  - Allow you to pay over time
  - No annual fee

Community Dentists of Worcester requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will recieve a refund less the cost of care provided and lab fees.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[3]

Community Dentists of Worcester charges $35 for returned checks and $25 for accounts sent to collections.[4]

You grant permission to us or our asignee, to telephone you to discuss this statement for your treatment.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of patient examination.

All emergency dental services, or any dental services performed without previous financial arrangements must be paid for at the time services ar eprovided unless other arrangements are made.

I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

If you have any questions, please do not hesitate to ask.

____

Patient, Parent or Guardian Signature Date

____

Patient Name (Please Print)

[1]Subject to credit approval

[2]Payment Plan must be paid in full before completion of services.

[3]However, if we do not receive payment from your insurance carrier within 60 days or after we make 3 attempts, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

[4]If your account balance is not settled at the time of appointment, our office will invoice you for the balance on a monthly basis for up to 3 invoices. Any account that is over 90 days past due will be assigned to a collection agency for further billing.

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 January 1st 2013, 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 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. You may also request access by sending us a letter to the address at the end of this Notice.)

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. Your 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.

Restrictions: 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:	Tania McPherson
Telephone:	508-686-7200
Fax:	978-342-8505
E-Mail:	tmcpherson@simplydentalmanagement.com
Address:	87 Elm Street #302, Hopkinton, MA 01748

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT**

I, ______________________________ have received a copy of this office's 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 obtained because:

____ Individual refused to sign

____ Communication barrier prohibited signing the acknowledgement

____ An emergency situation prevented from us obtaining acknowledgement

____ Other (please specify)

____

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