DANVERS
FAMILY DENTISTRY
enhancing smiles for a lifetime

7 FEDERAL ST. SUITE 25
DANVERS MA 01923
p. (978) 739.4100 *f.* (978) 739.4122
WWW.DANVERSFAMILYDENTISTRY.COM

Patient Registration Form

Patient Name _____ Date _____
I Prefer to be Called: _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Address _____ Apt. # _____
City _____ State _____ Zip _____
Home Phone _____ Business Phone _____
Cell Phone _____ E-mail _____
Social Security Number _____ Birth Date _____

Employer _____ Occupation _____
Business Address _____
City _____ State _____ Zip _____
Person Responsible for Account _____
Dental Insurance Company _____ Group # _____
Employee Name _____
Social Security Number _____ Birth Date _____

Emergency Contact _____ Relation to Patient _____
Home Phone _____ Business Phone _____ Cell Phone _____

Referred to us by _____
Previous Dentist Name & Address _____
_____
Date of Last Visit _____ Treatment Received _____
Reason for Leaving _____

Medical Questionnaire

ANY HISTORY OF:

Heart Problems.....	☐ YES	☐ NO	Bronchitis.....	☐ YES	☐ NO	Heart Valve Problems.....	☐ YES	☐ NO
High Blood Pressure.....	☐ YES	☐ NO	Fever Blisters/Herpes.....	☐ YES	☐ NO	Nose Obstruction.....	☐ YES	☐ NO
Rheumatic Fever.....	☐ YES	☐ NO	Stroke.....	☐ YES	☐ NO	Hypoglycemia.....	☐ YES	☐ NO
Emotional Stress.....	☐ YES	☐ NO	Thyroid Problems.....	☐ YES	☐ NO	Hyperglycemia.....	☐ YES	☐ NO
Asthma.....	☐ YES	☐ NO	Sinus Trouble.....	☐ YES	☐ NO	Prostate Problems.....	☐ YES	☐ NO
Blood Transfusions.....	☐ YES	☐ NO	Kidney or Liver Disease...	☐ YES	☐ NO	Lung Disease.....	☐ YES	☐ NO
Hepatitis.....	☐ YES	☐ NO	Glaucoma.....	☐ YES	☐ NO	Contact Lenses.....	☐ YES	☐ NO
Artificial Joints.....	☐ YES	☐ NO	Allergies.....	☐ YES	☐ NO	Cancer.....	☐ YES	☐ NO
Heart Murmur.....	☐ YES	☐ NO	Prolonged Bleeding.....	☐ YES	☐ NO	Ulcers.....	☐ YES	☐ NO
Cortisone or ACT II.....	☐ YES	☐ NO	Epilepsy/Convulsions.....	☐ YES	☐ NO	Emphysema.....	☐ YES	☐ NO
Anemia.....	☐ YES	☐ NO	Arthritis.....	☐ YES	☐ NO	Fainting or Dizzy Spells...	☐ YES	☐ NO
Positive Test for HIV.....	☐ YES	☐ NO	Diabetes.....	☐ YES	☐ NO	Epinephrine Sensitivity....	☐ YES	☐ NO

Do you have, or have you had, any diseases, conditions or problems not listed above?

If yes, please specify: _____

Are you being treated by a physician now or have you in the last six months? ☐ YES ☐ NO

Your Physician's Name _____

Physician's address & phone:_____

Are you taking any medications? ☐ YES ☐ NO (This includes over-the-counter drugs and prescription drugs)

If yes, please specify: _____

Are you allergic to any medications/blood thinners? ☐ YES ☐ NO

If yes, please specify: _____

Have you ever taken or been told to take antibiotics prior to dental treatment? ☐ YES ☐ NO

*If yes, what medication and dose have you taken?*_____

Any recent serious illnesses in the last 6 months? ☐ YES ☐ NO *If yes, please describe:* _____

_____

For women only: Are you pregnant? ☐ YES ☐ NO *If yes, what month?* _____

Are you nursing? ☐ YES ☐ NO

Are you on birth control? ☐ YES ☐ NO

Any other medical information you think we should be aware of?_____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

Consent:

I have answered all questions to the best of my knowledge. If further information is needed, you have my permission to ask my respective healthcare provider or agency who may release such information to you. I will notify this office of any changes in my health or medication. The undersigned hereby authorizes this office to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Upon such diagnosis, I authorize this office to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I understand that using anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 60 days. In the event of default, I/We promise to pay legal interest on indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. All diagnostic aids and documentation are the property of this office. Original records may not be taken by the patient. All records are strictly confidential. Signing this form authorizes us to transfer records to another dentist. I have reviewed a copy of this office's Notice of Privacy Practices and I have been notified that I may have a copy.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

Dental Questionnaire

Last Name_____ First Name_____ MI _____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Have you ever had any problems associated with previous dentistry? ☐ YES ☐ NO
   *If yes, please describe:*_____
2. Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely
3. Have you ever been treated for any type of gum problems? ☐ YES ☐ NO
4. Are you having any tooth or jaw joint discomfort at this time? ☐ YES ☐ NO
5. How often do you brush? _____Brush is: ☐ Soft ☐ Medium ☐ Hard ☐ Electric
6. Are you happy with the appearance of your teeth? ☐ YES ☐ NO
   If no, what would you change? _____
7. Do you have, or have you ever had, any of the following?

Mouth Problems:		Teeth Problems:	
Bleeding/sore gums	☐ YES ☐ NO	Loose teeth	☐ YES ☐ NO
Unpleasant taste/bad breath	☐ YES ☐ NO	Sensitive to hot	☐ YES ☐ NO
Burning tongue/lips	☐ YES ☐ NO	Sensitive to cold	☐ YES ☐ NO
Frequent blisters/lips/mouth	☐ YES ☐ NO	Sensitive to sweets	☐ YES ☐ NO
Swelling/lumps in mouth	☐ YES ☐ NO	Sensitive to biting	☐ YES ☐ NO
Ortho treatment (braces)	☐ YES ☐ NO	Food stuck in teeth	☐ YES ☐ NO
Biting cheeks/lips	☐ YES ☐ NO	Clenching/grinding	☐ YES ☐ NO
Clicking/popping jaw	☐ YES ☐ NO	*If so, when* _____	
Difficulty opening or closing jaw	☐ YES ☐ NO	Shifting in bite	☐ YES ☐ NO
Headaches	☐ YES ☐ NO	Change in bite	☐ YES ☐ NO

*If you answered yes to any of the above, please describe:*_____
_____

8. Do you use the following?

Brush	☐ YES ☐ NO	Dental Floss	☐ YES ☐ NO
Fluoride Rinse	☐ YES ☐ NO	Other _____	

9. Any other specific concerns or questions you have? _____
_____

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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.

YOUR RIGHTS:

When it comes to your health information, you have certain rights.

GET AN ELECTRONIC OR PAPER COPY OF YOUR MEDICAL RECORD

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

ASK US TO CORRECT YOUR MEDICAL RECORD

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

REQUEST CONFIDENTIAL COMMUNICATIONS

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

ASK US TO LIMIT WHAT WE USE OR SHARE

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information.

GET A LIST OF THOSE WITH WHOM WE'VE SHARED INFORMATION

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

GET A COPY OF THIS PRIVACY NOTICE

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

CHOOSE SOMEONE TO ACT FOR YOU

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

IN THESE CASES, YOU HAVE BOTH THE RIGHT AND CHOICE TO TELL US TO:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

IN THESE CASES WE NEVER SHARE YOUR INFORMATION UNLESS YOU GIVE US WRITTEN PERMISSION:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

IN THE CASE OF FUNDRAISING:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

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OUR USES AND DISCLOSURES:

How do we typically use or share your health information? We typically use or share your health information in the following ways:

TREAT YOU

- We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

RUN OUR ORGANIZATION

- We can use your health information and share it with other professionals who are treating you.

E*xample: A doctor treating you for an injury asks another doctor about your overall health condition.*

BILL FOR YOUR SERVICES

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

HELP WITH PUBLIC HEALTH AND SAFETY ISSUES

- We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

DO RESEARCH

- We can use or share your information for health research
- Comply with the law
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

RESPOND TO ORGAN AND TISSUE DONATION REQUESTS

- We can share health information about you with organ procurement organizations
- Work with a medical examiner or funeral director
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies

ADDRESS WORKERS' COMPENSATION, LAW ENFORCEMENT, AND OTHER GOVERNMENT REQUESTS

- We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

RESPOND TO LAWSUITS AND LEGAL ACTIONS

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

I Read and Understand. Patient Signature: _____Date: _____

Contact Officer: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____