

WORCESTER PERIODONTICS

PATIENT INFORMATION FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):		<input type="checkbox"/> M <input type="checkbox"/> F	Today's Date:
Birth Date:	Marital Status:	E-mail:	
Address:			
Primary Phone:		Secondary Phone:	
I prefer to be contacted by: email phone text			
In case of emergency please contact:			Phone:
Who may we thank for referring you?			
If under 18, who will be responsible for your account?		Relation:	Phone:

Dental Insurance? <input type="checkbox"/> Y <input type="checkbox"/> N	Insurance Company:	Employer:
Subscriber Name:	Birth Date:	Phone:
Group #:	I	ID# or SSN:

DENTAL INFORMATION

Reason for today's appointment		
When was your last dental exam?	Bleeding gums?	Sensitive teeth?
Food caught between teeth?	If you could change anything in your Smile what would that be?	

CONSENT FOR TREATMENT

A. I authorize the doctor or his/her staff to take x-rays, photographs, make models, or conduct other tests deemed necessary in order to make a thorough diagnosis by the doctor.

B. After making such diagnosis, I give permission to undertake the recommended treatment plan that has been mutually agreed upon.

C. I agree to the use of anesthetics and other medication as necessary, and further understand that these may carry certain risks. I understand that I may ask the doctor for a complete listing of possible complications.

Patient's Signature: _____	Date: ___/___/___
Parent/Responsible Party's Signature: _____	Date: ___/___/___

MEDICAL INFORMATION

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Reviewed by Dr. :	Date
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Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Who is your current primary care doctor? Yes No If yes _____

Do you currently see a doctor for speciality care? Yes No

Have you ever been hospitalized or had a major operation? Yes No If yes _____

Have you ever had a serious head or neck injury? Yes No If yes _____

Are you taking any medications (prescriptions and over the counter), vitamins or supplements on a daily basis? Yes No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes _____

Are you on a special diet? Yes No

Do you smoke or use tobacco? (cigaretts, vape, chew) Yes No

Do you use controlled substances? Yes No If yes _____

Women: Are you...

Pregnant/Trying to get pregnant?

Nursing?

Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin

Penicillin/Amoxicillin

Codeine

Acrylic

Metal

Latex

Sulfa Drugs

Local Anesthetics

Other?

If yes _____

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

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No	Sleep Apnea <input type="radio"/> Yes <input type="radio"/> No		

Have you ever had any serious illness not listed above? Yes No If yes _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____

Financial Policy Agreement

The goal of Worcester Periodontics is to provide exceptional customer service and excellent dental care with both a professional and personal touch. We want to make certain that our financial policies are clear and understood by you. If you have insurance, we will make a good faith estimate of your benefits and defer billing you for that amount **up to 60 days**. We will file the appropriate claim forms with your insurance company that you provide us with your personal information including social security number and date of birth. We will also assist you in understanding your dental plan benefits. If your insurance denies coverage, or if we do not receive payment within 60 days from the date services rendered, that amount will then become due and payable by you. Please remember that your coverage is a contract between you, your insurer and/or your employer. Although we will make every effort to help you obtain your benefits, we cannot guarantee your insurance will pay. When processing your payments, there will be a \$35.00 NSF fee for any payment made by check that does not clear. In addition, any administrative charges that may occur if an account is turned over to collections will be the responsibility of the patient.

Your payment is due at time of service

Fees for treatment are due at the time treatment is rendered after the deduction of your insurance benefit estimate as described above. Payment options: Cash, Check, Debit Card, Credit Card (Visa, Master Card, Discover Card) and Care Credit.

Patient Responsibility

I acknowledge my responsibility for payment of services rendered by Worcester Periodontics in accordance with Worcester Periodontics fees and terms. I understand my responsibility is not modified by whether any third party (insurance) pays for all, part or none of the charges. If the balance on your account is not paid within 30 days of statement, your account will become delinquent and will be forwarded to a third party collection agency. If this becomes necessary additional fees may be added to cover handling charges.

Assignment and release

I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all service not covered by my insurance and I authorize release of any medical care information requested by my insurance carrier. This agreement becomes effective the date the patient begins their first visit with Worcester Periodontics.

Records/ X-Rays

Worcester Periodontics understands that you have the right to request copies of your dental records/x-rays. *We can provide your notes and x-rays.* We are licensed by the Massachusetts Board of Radiology to take X-rays, and are required by law to keep all original copies of your dental records.

Cancellation Policy

Here at Worcester Periodontics of we understand that interruptions to our schedules can and will occur. We are aware that from time to time most people will encounter some unfortunate circumstances beyond their control. However, our time is scheduled in order to focus upon your oral health concerns. The team at Worcester Periodontics makes every effort to make your time at our office pleasant and productive. We take pride in the fact that our appointments are efficient and that you are not subject to lengthy waits in our reception area. All appointments when made have a specific date, time of day, and length of stay, so that you are better able to maximize your time here. With this in mind, we have developed a cancellation policy that is fair to both our patients and our practice. We are committed to seeing our patients on time and respecting their time. Late cancellations, failed appointments, and late arrivals are disruptive to our schedule and other patients. In order to maintain our schedule we request 48 hours notice for cancellations or rescheduling of appointments. In the instance of a late cancellation (less than 48 hours notice) or a failed appointment there will be a **\$50.00** cancellation fee.

Acknowledgement of Receipt of Statement of Privacy Practices/Cancellation Policy and Financial Policy

I acknowledge that I have received a copy of the Statement of Privacy Practices and Cancellation policy for the office of Worcester Periodontics. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility. Worcester Periodontics reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. We reserve the right to change our privacy practices at any time. You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Worcester Periodontics. We may decline treatment if you revoke this consent.

Name of Patient: _____

Date ___/___/_____

Signature of Patient: _____

Date ___/___/_____

Health Insurance Portability and Accountability ACT

The HIPAA Privacy Rule creates national standards to protect individual's medical records and other personal health information.

- It gives patients more control over their health information.
- It sets boundaries on the use and release of health records
- It establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information.
- It holds violators accountable, with civil and criminal penalties that can be imposed if they violate patient's privacy rights.
- And it strikes a balance when public responsibility supports disclosure of some forms of data-for example, to protect public health.
- For patients-it means being able to make informed choices when seeking care and reimbursement for care based on how personal health information may be used.
- It enables patients to find out how their information may be used, and about certain disclosures of their information that have been made.
- It generally limits release of information to the minimum reasonably needed for the purpose of the disclosure.
- It generally gives patients the right to examine and obtain a copy of their own health records and request corrections
- It empowers individuals to control certain uses and disclosures of their health information.
- Acknowledgement of receipt of Notice of Privacy Practice You may refuse to sign this acknowledgment

I, _____, have access to and read a copy of Worcester Periodontics' Notice of Privacy Practice, and understand my rights pertaining to my personal healthcare and insurance information.

Signature of Patient: _____

Date __/__/____

Signature of Witness: _____

Date __/__/____