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.):*	☐ M ☐ F	Today's Date:
Birth Date:	Marital status:	Email:
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?		

Who will be responsible for your account?			Relation:
Driver's License#:	Birth Date:	Phone:	
Address:			
Dental Insurance?	Company:	ID# or SS#	

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?	

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.

Are you under a physician's care now? Yes No If yes, please explain:
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain:
Have you ever had a serious head or neck injury? Yes No If yes, please explain:
Do you use tobacco? Yes No if yes, how much per day?
Do you use controlled substances? Yes No
Do you need to pre-medicate? Yes No If yes, please explain:

Women only	Any possibility of pregnancy?
	Expected delivery date?
	Nursing?
	Taking birth control?

MEDICATION HISTORY

Are you now taking or have taken:							
Nerve pills	☐ Yes ☐ No	Pain Killers (including Aspirin)	☐ Yes ☐ No	Stimulants	☐ Yes ☐ No		
Diet pills	☐ Yes ☐ No	Muscle Relaxers	☐ Yes ☐ No	Insulin	☐ Yes ☐ No		
Blood thinners	☐ Yes ☐ No	Tranquilizers.....	☐ Yes ☐ No	Antidepressants	☐ Yes ☐ No		
Any bone density medications (Boniva, Fossamax, Actonel)						☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers	

Are you allergic to or had a reaction to:					
Penicillin	☐ Yes ☐ No	Valium or other tranquilizers	☐ Yes ☐ No	Soy	☐ Yes ☐ No
Latex	☐ Yes ☐ No	Aspirin	☐ Yes ☐ No	Codeine or other narcotics	☐ Yes ☐ No
Sulfa	☐ Yes ☐ No	Local Anesthetics	☐ Yes ☐ No	Sulfites	☐ Yes ☐ No

HEALTH HISTORY					
AIDS/HIV Positive	☐Yes ☐No	Excessive Bleeding.....	☐Yes ☐No	Leukemia	☐Yes ☐No
Alzheimer's Disease.....	☐Yes ☐No	Kidney Problems.....	☐Yes ☐No	Stroke	☐Yes ☐No
Anaphylaxis.....	☐Yes ☐No	Stomach/Intestinal Disease.....	☐Yes ☐No	Liver Disease	☐Yes ☐No
Anemia.....	☐Yes ☐No	Irregular Heartbeat.....	☐Yes ☐No	Hives or Rash	☐Yes ☐No
Angina.....	☐Yes ☐No	Spina Bifida.....	☐Yes ☐No	Heart Pace Maker	☐Yes ☐No
Arthritis/Gout.....	☐Yes ☐No	Shingles.....	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
Artificial Heart Valve.....	☐Yes ☐No	Epilepsy or Seizures.....	☐Yes ☐ No	Hepatitis A	☐Yes ☐No
Artificial Joint.....	☐Yes ☐No	Convulsion.....	☐Yes ☐No	Hepatitis C	☐Yes ☐No
Asthma.....	☐Yes ☐No	Frequent Diarrhea.....	☐Yes ☐No	Hepatitis B.....	☐Yes ☐No
Chemotherapy.....	☐Yes ☐No	Radiation Treatments.....	☐Yes ☐No	Congenital Heart Disorder	☐Yes ☐No
Blood Disease.....	☐Yes ☐No	High Blood Pressure.....	☐Yes ☐No	Heart Attack.....	☐Yes ☐No
Blood Transfusion.....	☐Yes ☐No	Any Joint replacement	☐Yes ☐No	Hemophilia.....	☐Yes ☐No
Breathing Problem.....	☐Yes ☐No	Emphysema.....	☐Yes ☐No	Renal Dialysis.....	☐Yes ☐No
Bruise Easily.....	☐Yes ☐No	Frequent Cough.....	☐Yes ☐No	Sinus Trouble.....	☐Yes ☐No
Cancer.....	☐Yes ☐No	Tuberculosis.....	☐Yes ☐No	Tonsillitis.....	☐Yes ☐No
Chest Pains.....	☐Yes ☐No	Ulcers.....	☐Yes ☐No	Heart Murmur.....	☐Yes ☐No
Cortisone Medicine	☐Yes ☐No	Fainting Spells/Dizziness.....	☐Yes ☐No	Rheumatic Fever.....	☐Yes ☐No
Diabetes.....	☐Yes ☐No	Hypoglycemia.....	☐Yes ☐No	Parathyroid Disease.....	☐Yes ☐No
Drug Addiction.....	☐Yes ☐No	Excessive Thirst.....	☐Yes ☐No	Scarlet Fever.....	☐Yes ☐No
Frequent Headaches.....	☐Yes ☐No	Thyroid Disease.....	☐Yes ☐No	Lung Disease.....	☐Yes ☐No
Glaucoma.....	☐Yes ☐No	Mitral Valve Prolapse.....	☐Yes ☐No	Venereal Disease.....	☐Yes ☐No
Hay Fever.....	☐Yes ☐No	Pain in Jaw Joints.....	☐Yes ☐No	Psychiatric Care.....	☐Yes ☐No
Heart Attack/Failure.....	☐Yes ☐No	Tumors or Growths.....	☐Yes ☐No	Rheumatism.....	☐Yes ☐No
Heart Trouble/Disease.....	☐Yes ☐No	Yellow Jaundice.....	☐Yes ☐No	Recent Weight Loss.....	☐Yes ☐No
Low Blood Pressure.....	☐Yes ☐No	Herpes.....	☐Yes ☐No	Other	☐Yes ☐No

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 _____ DATE _____

Reviewed by Dr.	Date

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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.
D. I authorize Worcester Periodontics to deduct any outstanding balance on my account on my credit card a and/or any cancelation fees.

Patient's signature: _____ **Date:** ___/___/___

Parent/Responsible party's signature: _____ **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.

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 you 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.

*Initials*_____

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 (less than 48 hours notice) 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 an **$50.00** charge per **hour** of scheduled appointment and patient will be added to our waiting list.

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 right pertaining to my personal healthcare and insurance information.

_____ _____/_____/_____

Patient's Signature Date

_____ _____/_____/_____

Witness Signature Date

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.Parts 160 and 164)**

1. Authorization
I authorize _____Worcester Periodontics_____ (healthcare provider) to use and disclose the protected health information described below to _____General Dentist and Insurance__ (individual seeking the information).

2. Effective Period
This authorization for release of information covers the period of healthcare from:
a. □ _____ to _____.

OR
b. ☐ all past, present, and future periods.

3. Extent of Authorization
a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the exception of the following information:
□ mental health records
□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

X

signature of patient or personal representative

X

Printed name of patient or personal represent...

X

Date