DENTAL SURGEONS & IMPLANT CENTERS OF FALL RIVER AND DARTMOUTH

Patient Name:_____**Date**_____/____/_____ **Age**_____

Dentist_____**Primary Physcian**_____**PCP Tel#( )**_____ **Last Visit**____/_____/____

HAVE YOU EVER HAD OR HAVE YOU NOW: (*Please check at the RIGHT of **each** item*)

CHECK EACH ITEM (Use ink only)	YES	NO	DON'T KNOW	CHECK EACH ITEM (Use ink only)	YES	NO	DON'T KNOW	CHECK EACH ITEM (Use ink only)	YES	NO	DON'T KNOW
Epilepsy or Seizures				Hemophilia				Ulcers/Reflux			
Fainting or Dizziness				Bruise or bleed easily				Kidney problems			
Nervousness				Heart problems or Angina				Venereal disease			
Stroke				Hypertension (high BP)				Diabetes			
Glaucoma				Rheumatic fever				Thyroid disease			
Cold Sores (Herpes)				Heart Murmur				Arthritis			
Persistent Cough				Mitral valve prolapse				Painful joints			
Emphysema				Congenital heart lesion				Prosthetic joint(s)			
Tuberculosis/ PPD positive				Heart surgery				Hives			
Asthma				Prosthetic heart valve(s)				Steroid medication(s)			
Hay Fever				Pacemaker				Anxiety/Depression			
Sinus problems				Blood transfusion(s)				Alcoholism/Drug Addiction			
Anemia				Liver disease				Significant weight gain/loss			
Sickle cell disease				Hepatitis type:_____				Cancer/ Radiation treatment			
Chest Pain				Sleep Apnea				TMJ Problems			
Ankle swelling				Difficulty with anesthesia				Osteoporosis			
Birth control medication(s)				**Pregnant** _____ **Yes** _____ **No** **Estimated Delivery** _____							

Be aware that some medications can decrease the effectiveness of birth control pills.

1. DO YOU REQUIRE PRE-MEDICATION WITH ANTIBIOTICS PRIOR TO DENTAL TREATMENT FOR RHEUMATIC FEVER, HEART VALVE, JOINT REPLACEMENT OR KIDNEY DIALYSIS? _____ YES _____ NO

2a. DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE? If yes, please describe:

2b. ARE YOU UNDER THE CARE OF A PHYSICIAN? YES NO REASON?

3. DO YOU HAVE ANY **ALLERGIES**? IF YES, PLEASE LIST: (INCLUDING MEDICATIONS OR LATEX)

4. HAVE YOU HAD ANY SURGERIES OR HOSPITALIZATIONS? If yes, please list and date:

5. PLEASE LIST ANY MEDICATIONS & DOSAGES YOU TAKE ON A REGULAR BASIS: (INCLUDING HERBAL SUPPLEMENTS OR ASPIRIN)

6. DO YOU SMOKE OR CHEW TOBACCO? Yes_____ No_____ How much? How many years?

7. DO YOU USE STREET DRUGS INCLUDING MARIJUANA? Yes_____ No _____ How much? How many years?

8. DO YOU USE ALCOHOL? Yes _____ No _____ What do you use? How Frequently?

9. IS THERE ANYTHING YOU WISH TO DISCUSS PRIVATELY WITH THE DOCTOR? _____YES _____ NO

I certify that I have read & understand the above. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Please sign & date below: ***Patient*** ***(Parent or guardian if minor)***	Any change since last visit?	**Reviewing doctor's signature & date:**
X _____ **Date**		_____ Date _____
X _____ Date_____	___YES ___NO	_____ Date _____

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PATIENT INFORMATION

Name_____ Date _____

Address_____ City_____ State_____ Zip_____
*If the above address is a Po Box, you **must** provide a street address.

Home Phone No. _____ Cell Phone No. _____

SS# _____ Date of Birth _____ Age _____

Check Appropriate Box: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

If a student Name of School _____ City _____ State _____

Employer _____ Work Phone No. _____

Work Address _____ City _____ State _____ Zip _____

Person to contact in case of an Emergency _____ Phone No. _____

Responsible Party – Parent or Guardian if Minor

Name _____ Relationship To Patient _____

Address_____ City_____ State _____ Zip _____

Date of Birth _____SS#_____ Home/Cell Phone# _____

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 □ Credit Card □ 3rd Party Payment Plan

INSURANCE INFORMATION

First Middle Last | Relation to Patient

Date of Birth | Social Security Number

Employer | Work Phone Number

Employer Address | City | State | Zip

Medical Ins. Co. | Group # | Subscriber #

Dental Ins. Co. | Group # | Subscriber #

DO YOU HAVE ANY ADDITIONAL INSURANCE? □ Yes □ No If yes please complete the following:

First Middle Last | Relation to Patient

Date of Birth | Social Security Number

Employer | Work Phone Number

Employer Address | City | State | Zip

Medical Ins. Co. | Group # | Subscriber #

Please provide card(s) and photo ID. A photocopy is needed to verify benefits and eligibility.

DENTAL SURGEONS & IMPLANT CENTERS
OF FALL RIVER AND DARTMOUTH

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians practice, and any other use required by law.

Treatment: We will use and disclose you protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment from your health care services. For example, obtaining approval for a hospital stay may require that you're relevant protected Health information is disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities employee review activities, training or medical students, licensing, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate you physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity : Military Activity: and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to extent that your physician or the physicians practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, you may not inspect or copy the following records; psychotherapy noted; information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding , and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that ant part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on / or before April 14, 2003

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature: _____

Date: _____