

Dental Pro – New Patient Information Form

Patient Information

Full Name: _____

Date of Birth: ____ / ____ / ____ Age: _____

Male Female Other

Address: _____

City: _____ State: _____ Zip: _____

Phone Number(s):

- Home: _____

- Cell: _____

Email Address: _____

Preferred Method of Contact: Phone Text Email

Emergency Contact

Name: _____

Relationship: _____

Phone Number: _____

Insurance Information

Dental Insurance Company: _____

Policy Holder Name: _____

Relationship to Patient: _____

Policy / Member ID #: _____

Group #: _____

No dental insurance

Dental History

1. Reason for today's visit: _____

2. Date of last dental visit: _____

3. Have you experienced any of the following? (Check all that apply)

Tooth pain Bleeding gums Sensitive teeth

Jaw pain / clicking Headaches related to jaw

Difficulty chewing Bad breath None

4. Are you currently in pain? Yes No

If yes, please describe: _____

Medical History

5. Physician's Name: _____

Physician's Phone: _____

6. Are you currently under medical care? Yes No

If yes, explain: _____

7. Have you been hospitalized or had major surgery in the past 5 years? Yes No

If yes, explain: _____

Medical Conditions (Check all that apply)

YES NO Sleep Apnea

YES NO Diabetes

YES NO Asthma

YES NO Hepatitis

YES NO Emphysema/COPD

YES NO Bleeding Disorders

YES NO Seizure Disorder

YES NO Epilepsy

YES NO HIV / AIDS

YES NO Anemia

YES NO Heart Disease

YES NO Kidney Disease

YES NO Heart Attack

YES NO Liver Disease

YES NO High Blood Pressure

YES NO Osteoporosis

YES NO Heart Murmur

YES NO Artificial Heart Valve

YES NO Pacemaker

YES NO Stroke

- YES NO Thyroid Disease YES NO Autoimmune Disorder
 YES NO Arthritis YES NO Joint Replacement: _____
 YES NO Cancer (type): _____ YES NO Currently receiving chemo/radiation
 YES NO Other Medical Condition
 YES NO Anxiety YES NO Depression
 YES NO Panic Disorder YES NO Bipolar Disorder
 YES NO PTSD YES NO ADHD / ADD
 YES NO Schizophrenia YES NO Substance Use Disorder

Women's Health (if applicable): Pregnant Nursing Birth Control Menopause

Medications & Allergies

8. Are you currently taking medications? Yes No
 If yes, list: _____
 9. Do you have allergies? Yes No
 Medications Latex Food Other: _____
 Please list reactions: _____

Release of Records Authorization

10. I authorize **Dental Pro** to obtain/release my dental and/or medical records to:
 11. Recipient Name/Practice: _____
 Address: _____ Phone: _____ Fax: _____
 12. Purpose of Disclosure: Continuity of Care Insurance Personal Use Other:

 13. Information to Release: Entire Record Treatment Only X-Rays/Imaging
 Other: _____
 14. This authorization expires one year from the date signed unless otherwise specified:
 ____ / ____ / ____
 15. Patient/Guardian Signature: _____ Date: ____ / ____ / ____

Consent & Financial Responsibility

16. I authorize **Dental Pro** to perform necessary diagnostic and treatment procedures and accept financial responsibility for all charges not covered by insurance.

17. Patient/Guardian Signature: _____ Date: ____ / ____ / ____

HIPAA Notice of Privacy Practices

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

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 not be able to grant 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.

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 at the top of the page
- 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

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

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 and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

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.

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 website.

HIPAA – Acknowledgment of Receipt of Privacy Practices

18. I acknowledge that I have received **Dental Pro’s Notice of Privacy Practices**, which explains how my protected health information may be used and disclosed in accordance with HIPAA and Massachusetts state privacy laws (M.G.L. c.111 §70E).

19. Patient/Guardian Signature: _____ Date: ____ / ____ / ____

HIPAA – Communication Consent

20. I authorize **Dental Pro** to communicate with me regarding appointments, treatment, billing, and insurance. I understand that electronic communications may carry a risk of unauthorized access and that I may revoke this consent at any time.

21. Communication via (check all that apply):

Phone Voicemail Text Email

22. Preferred Phone: _____

Preferred Email: _____

23. Patient/Guardian Signature: _____ Date: ____ / ____ / ____

Informed Consent - Direct & Indirect Restorations

- I have been advised of and understand that treatment of dental conditions requiring crowns, fixed bridgework and/or fillings includes certain risks and possible unsuccessful results, including the possibility of failure. Even when care and diligence is exercised in the treatment of conditions requiring crowns, bridgework, fillings and fabrication of same, there are no promises or guarantees of anticipated results of the length of time that the restoration will last.

Potential Benefits:

While there are risks to all dental treatment, including direct and indirect restorations, I agree to assume the risks associated with the restoration, as the benefits outweigh the risks. These benefits may include:

- **Strengthening of tooth structure**
- **Replacing a damaged or broken tooth**
- **Protecting a worn tooth**
- **Removing tooth decay**
- **Reducing or eliminating discomfort**
- **Anchorage for a dental appliance**

Risks include but are not limited to the following:

- **Reduction of tooth structure:** To replace decayed or otherwise traumatized teeth, it is necessary to modify the existing tooth or teeth so that restoration can be placed on/in them. Tooth preparation will be done as conservatively as practical.
- **Numbness following use of anesthesia:** In preparation of teeth, anesthetics are usually needed. As a result of the injection, there may be swelling, jaw muscle tenderness or even resultant numbness of the tongue, lips, teeth, jaws and/or facial tissues that is usually temporary; in rare instances, such numbness may be permanent.
- **Sensitivity of teeth:** Often, after the preparation of teeth for the reception of either crown, bridges and composite resin fillings the teeth may exhibit sensitivity. It may be mild to severe. This sensitivity may last only for a short period of time or for much longer periods. If it is persistent, notify us so that we can determine the cause of sensitivity and seek to treat the condition.
- **Necessity for root canal therapy:** The preparation of the teeth often requires the removal of adequate tooth structures to ensure that the diseased or otherwise compromised tooth structure provides sound tooth structure for placement of the restoration. At times, this may lead to exposure or trauma to underlying pulp tissues. Infrequently, the tooth or teeth may abscess or otherwise not heal, which may require root canal treatment, root surgery or possibly extraction.
- **Breakage:** Crowns, bridges and composite resin fillings may chip or break. Many factors could contribute to this situation such as chewing excessively hard materials, change in biting forces, traumatic blows to the mouth, etc. Undetectable cracks may develop in dental materials from these causes, but the restoration themselves may not break until sometime later. Breakage or chipping because of defective materials or construction is somewhat uncommon, and if it occurs, it's usually soon after placement.
- **Uncomfortable or Strange Feeling:** Crowns, bridges and composite resin materials are artificial and therefore feel different from natural teeth. Most patients usually become accustomed to this feeling of their new restoration over time. In limited situations, muscle soreness or tenderness of the jaw joints - temporomandibular joint (TMJ) syndrome - may persist for indeterminable periods of time following placement of the prosthesis.
- **Esthetics or Appearance:** Patients will be given the opportunity to observe the appearance of crowns or bridges in place prior to final cementation. Composite resin fillings are matched to the shade of surrounding teeth to the best of your providers ability.
- **Longevity of Restoration:** Many variables determine how long restorations can be expected to last. Among these are some of the factors mentioned in the preceding paragraphs, including the general health of the patient, oral hygiene, regular dental checkups and diet. As a result, no guarantees can be made or assumed to be made regarding the longevity.
- **Risk of Fracture** Inherent in the placement or replacement of any restoration is the possibility of the creation of fracture lines in the tooth structure. Sometimes these fractures are not apparent at the time of removal of the tooth structure and/or the previous filling and placement or replacement, but they can appear at a later time.
- **Risk of Future Treatment:** The patient must diligently follow any and all instructions, including the scheduling of and attendance at all appointments. Failure to keep the cementation appointment can result in ultimate failure of the crown/bridge to fit properly and an additional fee may be assessed.

I have been given the opportunity to ask questions regarding the nature and purpose of my treatment and have received answers to my satisfaction. I voluntarily assume any and all possible risks including those listed about and including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. By signing this document, I am freely giving my consent to allow and authorize my dentist and/or his/her associates to render any treatment necessary and/or advisable to my dental conditions including the prescribing and administering of any medications and/or anesthetics deemed necessary to my treatment.

Office Use Only:

I have reviewed the information contained within this packet.

Doctor signature: _____

Date: _____