PREMIER DENTAL GROUP
of Wellesley, P.C.

PATIENT REGISTRATION & CONSENT

TODAYS DATE_____

NAME:_____
LAST FIRST

ADDRESS:_____

_____

DATE OF BIRTH:_____
SS # (FOR INSURANCE)_____
HOME #._____

CELL #._____

WORK #._____

E-MAIL:_____

EMPLOYER:_____

Other family members seen by us?_____
Previous/Present Dentist:_____

Last visit date:_____

PRIMARY DENTAL INSURANCE
Insurance Co. Name:_____
Address:_____
Phone #:_____
Subscriber ID#:_____
Group #_____
Policy Holder Name:_____
DOB:_____Employer:_____
Policy Holder's SS #_____
Relation to patient:_____

SECONDARY DENTAL INSURANCE
Insurance Co. Name:_____
Address:_____
Phone #_____
Subscriber ID#_____
Group #_____
Policy Holder Name:_____
DOB:_____Employer:_____
Policy Holder's SS#_____
Relation to patient:_____

Person Responsible for Account:_____
Address & Phone # if different:

_____

_____

SPOUSE INFORMATION
Name:_____
Employer:_____
Work #:_____
Cell #:_____
SS #:_____

IN the event of an emergency, is there someone who lives near you that we should contact?
Name:_____
Phone:_____
Relation:_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical or insurance status. **I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.**
Cell Phone/E-mail Consent: I authorize the dental staff to call or text me regarding appointments, treatment, insurance and my account.

_____
Signature Date

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

MEDICAL HISTORY

PREMIER DENTAL GROUP
of Wellesley, P.C.

PT. NAME_____

DATE_____

Your current physical health is: **Good-Fair-Poor**

Are you currently under the care of a physician?

No Yes (if yes please explain):

_____

Do you have a personal physician? Yes No

Physician's Name:_____

***DO YOU REQUIRE PRE-MEDICATION WITH AN ANTIBIOTIC PRIOR TO DENTAL TREATMENT?**

NO **YES**

List antibiotic that you take and reason for taking it

_____

_____

Are you taking any prescription drugs? No Yes

Please list:_____

_____

_____

Do you smoke/use alcohol?_____

Are you taking Fosamax or any medication for osteoporosis or bone density?

_____

Are you on Coumadin or aspirin?_____

ALLERGIES

Are you allergic to any of the following drugs?

Penicillin	Tetracycline	Latex
Aspirin	Dental Anesthetics	Codeine
Erythromycin	Sulfur Drugs	

Other:_____

_____

DENTAL HISTORY

Your current dental health is: **Good-Fair-Poor**

No Yes Are you currently in pain?

No Yes Are your teeth sensitive?

No Yes Have you ever had Nitrous Oxide?

No Yes Do you now or have you ever experienced Pain/discomfort in your jaw (TMJ/TMD)?

No Yes Do you wear a niteguard/biteguard?

No Yes Do your gums bleed?

No Yes Do you like your smile?

How many times a week do you floss?_____

How many times a day do you brush?_____

Have you had or do you have any of the following? (please circle)

Bypass Surgery/Stent	Tuberculosis (TB)
Heart Attack/Stroke	Blood Transfusion
Artificial Valves	Sinus Problems
High/Low Blood Pressure	Glaucoma
Congenital Heart Defect	Psychiatric Problems
Mitral Valve Prolapse	Epilepsy/Seizures
Cancer/Chemo.	Diabetes
Radiation Treatment	Hemophilia/Abnormal Bleeding
Artificial Bones/Joints	
Drug/Alcohol Abuse	Difficulty Breathing/ Emphysema
Venereal Disease	
Severe/Frequent Headaches	
Hay fever/Allergies	Arthritis
Shingles	Asthma
HIV/AIDS	Kidney Problems
Liver Problems	Hepatitis/Jaundice

Hospitalized for any reason? No Yes

If yes, why?_____

Please list any serious medical conditions that you have ever had: (Women: Are you Pregnant? Taking Birth Control?)_____

_____

_____

Are you interested in improving any of the following?

No Yes Your Smile

No Yes Shape of your teeth

No Yes Color of your teeth

No Yes Position of your teeth

No Yes Closing spaces between your teeth

No Yes Have you ever had orthodontic care?

No Yes Have you ever had periodontal care?

No Yes Have you ever had root canal treatment?

No Yes Have you ever had implant treatment?

No Yes Are you interested in replacing missing Teeth?

No Yes Are you interested in white fillings?

PREMIER DENTAL GROUP OF WELLESLEY, P.C.

Office Financial Policy

We would like to take this opportunity to tell you our fees are based on skill, knowledge, service, time, and costs. We are sensitive to the escalation of health care costs and try to keep our expenses in check. Our greatest concern is to offer you and your families the quality of service that we would choose for ourselves.

Payment is expected for treatment when it is given. If there are financial conditions that make it difficult for you to keep your account current, please speak with us. We have various payment options so that both parties are comfortable.

Your dental insurance coverage may or may not include benefits for services rendered in this office. The benefits are in accordance with the terms set down at the time of purchase by either your employer or yourself. You are financially responsible for the services provided by the office whether you have dental coverage or not. As a further benefit to our patients we offer an in-office dental plan specific to our office. Please ask us about this service.

The fees we charge for service to our patients who are insured, are our usual and customary fees charged to all patients for similar services. The allowable benefits of your insurance policy may or may not coincide with these fees. There is a relationship between this office and the patient, but none to the insurance company, regardless of contract or company. We do however; participate with Blue Cross Blue Shield of MA and Delta Dental of MA.

We are happy to assist you in obtaining allowable benefits, and to process the required forms at no charge, despite the time necessary to do so. The responsibility to see that the benefits are recovered is yours alone. All fees will be discussed prior to treatment and payment arrangements provided. This is to be the responsibility of the patient to this office and not through or with the insurance company.

As a courtesy, we will submit a pretreatment estimate form, if requested. You may begin treatment with the understanding that we do not know what your insurance will cover. A deposit is required for all crown and bridge work or extensive treatment over $1000. Should you wish a pre-treatment estimate before beginning, please ask. We accept Visa, MasterCard, and American Express.

Twenty-four hour notice is required for all cancelled appointments. This way we can make time available for someone who needs it. A fee will be charged for last minute cancellations or failures as this affects opportunities for other patients that are waiting, your insurance company will not cover these fees.

Unless specific payment arrangements have been made, interest charges [1.5% per month] will be assessed for late payments beginning with the second billing period after the work is completed. Please do not hesitate to call if you have any questions regarding treatment, fees, or bills. All questions are important.

Sincerely,

PREMIER DENTAL GROUP OF WELLESLEY, P.C.

_____

Patient Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

Premier Dental Group
(Practice Name)

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

You May Refuse to Sign This Acknowledgment of Receipt

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify)

_____

_____

_____

If you are not present, able to agree or object to the use or disclosure (such as in an emergency situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

State-Specific Requirements: Many states have reporting requirements, which may include population-based activities relating to improving health or reducing health care costs, cancer registries, birth defect registries and others.

Your Health Information Rights

Although your health record is the physical property of the practice that compiled it, you have the right to:

Inspect and Copy: You and/or your personal representati ve have the right to inspect, review and receive a copy of your medical information. Electronic copies are available and may include various electronic means such as a patient portal or other reasonable accommodations requested. We may deny your request to inspect and copy in limited circumstances to include release of psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. If you are denied access to medical information, you may request that the denial be reviewed.

Requests to copy and/or a review must be submitted in writing to Premier Dental Group of Wellesley. There will be a fee charged for all applicable copying and producing copy of portable media (CD, USB) up to the maximum amount as prescribed by governing law.

Amend: If you feel that the medical information we have is incomplete or incorrect, you may ask us to amend the information by submitting a request in writing.

An Accounting of Disclosures: You have the right to request an accounting of our disclosures of your medical information; the list will not include disclosures to carry out treatment, payment and health care operations. The dental practice of Premier Dental Group of Wellesley will provide the first accounting to you in any 12-month period without charge, upon receipt of your written request. The cost for subsequent requests for an accounting within the 12-month period will be up to the maximum amount prescribed by governing law.

Request Restrictions: You have the right to request a restriction or limitation of your medical information we use or disclose about you for treatment, payment or health care operations. *Restrictions from your health plan (insurance company)*: You have the right to request that we restrict disclosure of your medical information to your health plan for covered services, provided the disclosure is not required by other laws. You must pay services in full, out of pocket. *Other Restrictions, Limiting Information:* You also have the right to request and limit any medical information we disclose about you to someone who may be involved in your care or the payment of your care, such as a family member or friend. We ask that you submit these requests in writing.

We may not agree or be required to agree to your request(s) for specific reasons, if this occurs, you will be informed of the reason(s) for the denial.

Request Confidential Communications: You have the right to request that we communicate with you about medical/dental matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you may request that we use an alternate phone number or address. We ask that you submit these requests in writing.

Email communication and texting requests if applicable will require a separate authorization. To exercise any of your rights, please submit your request in writing to the practice's privacy officer indicated below.

For More Information or to Report a Problem

If you have questions and would like additional information please contact the Privacy Officer. If you believe that your (or someone else's) privacy rights may have been violated, you may file a complaint with the Privacy/Security Officer at the contact number below or with the Secretary of Health and Human Services at 800-368-1019. Further instructions for filing a complaint can also be found at www.hhs.gov/ocr. All complaints must be submitted in writing within 180 days of when you knew that the act or omission occurred. There will be no retaliation for filing a complaint.

Telephone Number: 781- 237-3031
Privacy Officer: Susan Kane
Security Officer: Susan Kane

PREMIER DENTAL GROUP
of Wellesley, P.C.

70 Walnut St
Wellesley, MA 02481

Phone: (781)-237- 3031
Fax: (781)-237- 3968
www.premierdentalgroupofwellesley.com

Notice of Privacy Practices

Health Insurance Portability and Accountability Act of 1996 (2001, 2003 and 2013)

Last Modified: May 24, 2018

Prepared by LD&A and HARLLC. Given the complexity of the HIPAA Privacy, Security and HITECH laws this information is prepared as required by law and with the understanding that LD&A and HAR LLC are not engaged in rendering legal services or advice.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact our Privacy Officer at the number listed at the end of this Notice. Each time you visit a healthcare provider, a record of your care is created. Typically, this record contains medical/dental information such as your symptoms, examination, test results, diagnoses, treatment and/or treatment plan and billing-related information. This information is considered protected health information (PHI).

This Notice is intended to advise you about the ways we may use and disclose medical information about you. It also describes your rights and certain obligations with regard to your medical information and applies to all of the records of your care generated by your healthcare provider(s) for our organization.

Our Responsibilities

The dental practice of Premier Dental Group of Wellesley is required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on 5/9/16 and will remain in effect until we replace it. We are required by law to abide by the terms of this Notice and notify you if changes are made. We reserve the right to make changes to the Notice and make the new provisions effective for all protected health information we maintain.

Copies of our Notice are available at our main reception area and on our website. You may request a copy of the NPP at any time

How We May Use and Disclose Medical Information About You. We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

For Treatment: We may use and disclose your health information for your treatment. For example, we may disclose your health information to specialists, referring dentists, nurses, physicians, technicians, clinical laboratories, imaging centers, dental students, or other personnel who are involved in your care. We may communicate your information using various methods: orally, written, facsimile and electronic communications.

We may provide other healthcare professionals who contribute to your care with copies of various reports and information to assist him/her and ensure that they have appropriate information regarding your condition/treatment plan and diagnosis.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. Examples may include contacting your insurance company for referrals, verification or preapproval of covered services.

For Health Care Operations: We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to quality assessments, employee review activities, licensing, legal advice, accounting support, information systems support. We may contact you to remind you of your appointment by telephone or reminder card unless requested otherwise.

Business Associates, BA: Provide services for our organization through written contracts and/or service agreements. Examples of these services may include IT service, software support, accounting and legal support. We may disclose your health information to a BA so they can perform the services we have asked them to do such as billing your third-party payer for services rendered. The BA is also required by law to protect and safeguard your health information, which is clearly defined through our Business Associate Agreement and written contracts/service agreements.

Breach Notification: In the event that there has been a breach of unsecured protected health information (PHI) identified on behalf of our organization or a BA you will be notified within at least 60 days of the breach. In addition to your individual notification we may be required to meet further reporting requirements set forth by state and federal agencies.

Uses and Disclosures That May Be Made *With* Your Consent, Authorization or Opportunity to Object

We will not use and disclose information without your written authorization, except as described in this Notice or as required by applicable laws.

Written authorization is required for, most uses and disclosures of psychotherapy notes; PHI for marketing purposes unless we speak with you and disclosures that constitute a sale of PHI.

If you provide an authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your authorization.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Future Communications: We may communicate with you via newsletters, mailings, texting or other means regarding treatment options and information on health-related benefits or services; to remind you that you have an appointment; or other community based initiatives or activities to include limited marketing or fundraising initiatives in which our facility is participating. You have the right to ***opt out*** at any time if you are not interested in receiving these communications or methods of communications. Please contact our Privacy Officer. Marketing and Fundraising initiatives, if applicable are limited and may require a separate authorization.

Uses and Disclosures That May Be Made *Without* Your Authorization or Opportunity to Object. We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

As required by law: We may use and disclose health information to the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- Authority that receives reports on abuse and neglect