ATTLEBORO FALLS
FAMILY DENTISTRY

Name: ____ ______________

Last First MI Date of Birth

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: ___________________________ Physician's Phone: __________________________________

Date of last visit: ____________________________________

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Emergency Contact: __________________________ Relationship: _________________ Phone: _______________

Do you use tobacco in any form? ❑ Cigarette ❑Smokeless ❑ Cigar ❑ Hookah ❑ Pipe ❑ Marijuana

If yes, how often: ____

Have you had any metal rods, pins or implants placed? ❑ Yes ❑ No

Are you taking any medications? (Including vitamins and herbal drugs) ❑ Yes ❑ No

Please list each one: ____

Have you ever had any surgical procedures? ❑ Yes ❑ No

Please list each one: ____

Yes	No	Conditions
❑	❑	Abnormal Bleeding
❑	❑	Allergies
❑	❑	Anemia
❑	❑	Angina Pectoris
❑	❑	Arthritis
❑	❑	Artificial Heart Valve
❑	❑	Asthma
❑	❑	Autoimmune Disorder
❑	❑	Cancer
		If so, Year______ Type_____________
❑	❑	Chemotherapy
❑	❑	Congenital Heart Defect
❑	❑	Development Disorder
❑	❑	Diabetes
❑	❑	Difficulty Breathing
❑	❑	Emphysema
❑	❑	Epilepsy
❑	❑	Facial Surgery
❑	❑	Fainting Spells
❑	❑	Frequent Headaches
❑	❑	Glaucoma
Yes	No	Conditions
❑	❑	HIV/AIDS
❑	❑	Heart Attack; if so, Year______
❑	❑	Heart Murmur
❑	❑	Heart Surgery
❑	❑	Hemophilia
❑	❑	Hepatitis
❑	❑	High Blood Pressure
❑	❑	Joint Replacement
		If so, Year_____ Joint__________
❑	❑	Kidney Problems
❑	❑	Liver Disease
❑	❑	Low Blood Pressure
❑	❑	Mitral Valve Prolapse
❑	❑	Pace Maker
❑	❑	Psychiatric Problem
❑	❑	Radiation Therapy
❑	❑	Seizures
❑	❑	Sexually Transmitted Disease
❑	❑	Sinus Problems
❑	❑	Sleep Apnea
❑	❑	Stroke/TIA; if so, Year______
Yes	No	Conditions
❑	❑	Substance Abuse
❑	❑	Thyroid Problems
❑	❑	Tuberculosis

Yes	No	Allergies
❑	❑	Aspirin
❑	❑	Codeine
❑	❑	Dental Anesthetics
❑	❑	Erythromycin
❑	❑	Latex
❑	❑	Penicillin
❑	❑	Sulfa
❑	❑	Tetracycline
❑	❑	Other:_________________

Yes	No	If Female, Please Answer:
❑	❑	Are you taking Birth Control Pills?
❑	❑	Are you Pregnant If so, how many weeks? ___________
❑	❑	Are you nursing?

Do you have any condition not listed above? If so, please explain_______________________________________

____

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 status. Signature: ___________________________________ Date: _________________________

ATTLEBORO FALLS
FAMILY DENTISTRY

Dental History

Name: ____
Last First MI Title

How may we help you today? ____

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Have you ever had gum treatment? ❑ Yes ❑ No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ❑ Yes ❑ No

Are you under stress? (New job, moving, relationships) ❑ Yes ❑ No

Do you like your smile? ❑ Yes ❑ No

Is there anything you would like to change about your smile? ❑ Yes ❑ No

Are you happy with the color of your teeth? ❑ Yes ❑ No

Do your gums bleed? ❑ Yes ❑ No

How many times a do you: floss/week?__________ brush/day?__________

Are your teeth sensitive to heat, cold or anything else? ❑ Yes ❑ No

Have you lost any teeth? ❑ Yes ❑ No

Have you ever had a serious/difficult problem with any previous dental work? ❑ Yes ❑ No

Have you ever had any unfavorable dental experiences? ❑ Yes ❑ No

When was your last dental cleaning? ____

When was your last dental visit? ____

Why did you leave your previous dentist? ____

How can we accommodate you better during your dental visit? ______________________

____

Here at Attleboro Falls Family Dentistry we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Tooth Whitening	Veneers/Lumineers	Traditional Orthodontics
Partials/Dentures	Bonding	Sealants
Crown and Bridge	Implant Crowns	Night/Sport Guard

Dental Health Questionnaire for Children and Teenagers

Patient Name: ____________________________ DOB: _________

A child and teenagers dental health is affected by many different things. The three most important to developing teeth are home dental care (Brushing, flossing, and the use of fluoride), any habits relating to the mouth or teeth, and your child's diet. To help us better evaluate your child's dental health, please answer the following questions: (Please circle 'YES' or 'NO' where appropriate)

Home Dental Care

1. Does your child brush his/her own teeth? YES NO

    How often? Times per day _____times per week _______

2. Do you assist or check the quality of brushing of your child's teeth? YES NO

    How often? Times per day _____times per week _______

4. Does your child floss his/her teeth? YES NO

    How often? Times per day _____times per week _______

Habits

1. Did/does your child suck his/her thumb or finger? YES NO

    _______Stopped at age ________Still does _______Only at night

2. Does your child grind his/her teeth? YES NO

4. Does your child play sports? YES NO

    What sport (s)? ____

5. Does your child wear a sports mouth guard? YES NO

Diet

1. Does your child frequently consume soda, candy, juices, or sports drinks? YES NO

    If yes, how often? ____

2. Was/ is your child allowed to consume sugary food after brushing at night? YES NO

3. Does your child chew gum with sugar in it? YES NO

    If yes, how often? Times per day ______times per week _______

4. How many between meal snacks including drinks other than water does your child have on an average day? ____________

Sleep Screening Questionnaire

Please answer the questions below to help us assess the possibility of a sleep disorder which may be related to your dental and overall health. There is often a correlation between grinding of the teeth, TMJ disorders, breakdown of the teeth and sleep disorders. Sleep apnea may also increase your risk for many different health conditions including heart attack and stroke. If you are here with your child (under 16), please fill out the lower portion marked "For children only" for your child.

Name:____**Height:**_______________**Weight:**_______________

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze
1 = I have a slight chance of dozing
2 = I have a moderate chance of dozing
3 = I have a high chance of dozing

Situation	Chance of Dozing
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting inactive in a public place (e.g. a theater or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch without alcohol	_____
8. In a car while stopped for a few minutes in traffic	_____
Total Score	_____

Have you ever been diagnosed with:	**Yes**	**No**
1. Impaired Cognition (i.e. difficulty concentrating or thinking)	☐	☐
2. Mood Disorders/Depression	☐	☐
3. Insomnia	☐	☐
4. Hypertension (high blood pressure)	☐	☐
5. Ischemic Heart Disease (Coronary Artery Disease/Atherosclerosis)	☐	☐
6. History of Stroke	☐	☐
7. Sleep Apnea	☐	☐
If yes: Did you try to use CPAP	☐	☐
8. TMJ problems significant enough to require treatment	☐	☐
9. Gastric Reflux (GERD) or Heartburn	☐	☐

Are you aware of (or have you been told):	**Yes**	**No**
1. Snoring on a regular basis	☐	☐
2. Feeling tired or fatigued on a regular basis	☐	☐
3. Clenching or grinding your teeth (bruxism)	☐	☐
4. Having frequent headaches	☐	☐
5. Your neck size being > 17 inches (male) or > 16 inches (female)	☐	☐
6. Anyone in your family having sleep apnea	☐	☐
7. Stopping breathing when sleeping/awakening with a gasp	☐	☐

For children only (filled out by parent or guardian)

Are you aware of your child:	**Yes**	**No**
1. Snoring/noisy breathing while sleeping	☐	☐
2. Grinding his or her teeth	☐	☐
3. Wetting the bed	☐	☐
4. Having difficulty in school/learning	☐	☐
5. Being treated for ADD or ADHD	☐	☐
6. Breathing primarily through their mouth	☐	☐
7. Having frequent nightmares/night terrors	☐	☐
8. Having frequent ear aches	☐	☐

Dental Exam Findings: ☐ **Evidence of Bruxism** ☐ **Scalloping of the tongue** ☐ **Crowded airway** ☐ **Tori or Bone Loss** ☐ **Anterior wear** ☐ **Retrognathia / Class II**

Name: ____
Last First MI Title

Preferred Name ______________________________ ☐ Male ☐ Female

Address: ______________________ City ______________ State ____ Zip __________

SSN: ______________________ DOB: ______________________

Home Phone:______________________ Work Phone: ______________________

Cell Phone: ______________________ E-mail Address: ______________________

Employer: ______________________ Occupation: ______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

How did you hear about our office?______________________________

Do you prefer to be contacted for appointment confirmation via e-mail or phone? *(Please circle preference)*

Insurance — Primary

Subscriber Name: ______________ Relationship to Patient: __________ Subscriber DOB: ________

Subscriber SSN/ID: ______________ Group Number: ______________________

Insurance Company Name: ______________________________

Insurance Company Address: ______________________________

Insurance Company Phone: ____________ Subscriber Employer: ______________________

Insurance – Secondary

Subscriber Name: ______________ Relationship to Patient: __________ Subscriber DOB: ________

Subscriber SSN/ID: ______________ Group Number: ______________________

Insurance Company Name: ______________________________

Insurance Company Address:______________________________

Insurance Company Phone: ____________ Subscriber Employer: ______________________

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Today's Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: ______________________________

Relationship: ______________________ Date: ______________________

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: ______________________________

Attleboro Falls Family Dentistry
1 Lyons Way
Attleboro Falls, MA 02763

Financial Policy

Thank you for choosing us as your dental care provider. Our primary concern is that you receive appropriate treatment needed to restore and maintain optimal dental health. We also realize the importance of good communication with our patients regarding their treatment, the fees involved and our Financial Policy

We ask that all patients read and sign the following Financial Policy. The signed copy will be kept with your records here at Dental Associates and you will be given a copy to take with you.

Payment is due at the time services are rendered. Returned checks and outstanding balances older than 30 days are subject to additional collection fees and interest charges of 1.5% per month.

Payment Options:

1. *Cash ---includes money orders and personal checks.*
2. *Visa/MasterCard and Discover*
3. *CareCredit and Wells Fargo---the monthly payment plan we offer for services over $300.00 as a separate line of credit to cover you and your family members' health care needs. With CareCredit and Wells Fargo:*
   . *Approval usually only takes a few minutes*
   . *They offer No Interest Option:*
   . *They also offer low interest Extended Payment Plan options, for more time to pay your balance.*
   . *No annual fees or prepayment penalties*

Insurance

We do accept most dental insurance plans and assignment of benefits. We are happy to submit claims providing we have all necessary information.
Please understand that:

1. *Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.*
2. *We cannot render services on the assumption an insurance company will pay the charges. All charges are your responsibility from the date the services are rendered.*
3. *Deductibles and co-payments are due at the time of service. Credits and duplicate payments are refunded immediately by our office.*
4. *Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.*
5. *Remember; please update our office staff regarding any changes to your dental insurance policy, so that we may process your claim in a timely manner.*

I HAVE READ THE POLICIES DESCRIBED IN THIS FORM. I AGREE TO ABIDE BY THE TERMS OUTLINED. I UNDERSTAND AND ACCEPT MY FINANCIAL RESPONSIBILITY.

____

SIGNATURE ***DATE***

Notice of Privacy Practices

Attleboro Falls Family Dentistry

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

We are 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 __9_/_22_/_13_, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH 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.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or

required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: ______________Donald A. Pierce DDS_______________________
Telephone: ___508-699-9550_____________ Fax: ____508 699-1596_________________
Address: ______1 Lyons Way   Attleboro Falls, MA 02763___________________________
E-mail: _____________Attleborofallsdentistry@comcast.net________________________________

.

Acknowledgement of Receipt of HIPAA Policies and Procedures

______Attleboro Falls Family Dentistry________

I have received and reviewed a copy of our dental practice's privacy, security and breach notification policies and procedures.

I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

Print Name:____

Signature:____

Date:____

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances or a poor outcome.

Please read and initial the items below and sign the bottom of the form.

1. Treatment to be Provided

I understand that during my course of treatment that the following care may be provided:

Examinations, Preventive services, Restorations (fillings), Crowns, Periodontal (gum) treatment.

Patient Initials _____

2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

Patient Initials _____

3. Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. Following a verbal discussion regarding my care, I give my permission to the dentist to make any/all changes and additions as necessary. Patient Initials _____

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. Patient Initials _____

____________________	____________________	____________________
Patient Name (Print)	Patient Signature	Date