North Country Dental New Patient Packet - Adult

Today's Date: _____

PATIENT INFORMATION

First Name:_____ M.I.:_____ Last Name:_____ Sex: M F

DOB:____/_____/_____ SSN:_____ Driver's Lic#:_____ E-Mail:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Physical Address (if different):_____

Home Phone: (____)_____-_____ Cell: (____)_____-_____ Work:(____)_____-_____ ext _____

Have you ever been a patient of our practice? □ Yes □ No If YES, When:_____

How did you hear about our practice? _____

In case of an emergency, please contact:_____ Tel. (____) ____-_____ Relation: _____

RESPONSIBLE PARTY

□ Self (if self, skip this section) □ Other (please complete information below)

First Name:_____ M.I.:_____ Last Name:_____ DOB:____/_____/_____

SSN:_____Relation:_____ Mailing Address: _____

Physical Address (if different):_____

INSURANCE INFORMATION

Student: □ Full Time □ Part Time □ N/A School Name:_____

Marital Status: □ Married □ Divorced □ Widow □ Single □ Legally Separated

Employer: □ Full Time □ Part Time □ Retired

PRIMARY DENTAL INSURANCE

Employer:_____

ID#:_____ Group#:_____

Ins Co. Name:_____

Address:_____

Tel. (___)____ -_____

Primary Subscriber:_____

Address:_____

Relation:_____ DOB: ____/____/_____

SSN:_____ Tel. (____)_____-_____

Do you belong to a PPO? □ Yes □ No

SECONDARY DENTAL

Employer:_____

ID#:_____ Group#:_____

Ins Co. Name:_____

Address:_____

Tel. (___)____ -_____

Primary Subscriber:_____

Address:_____

Relation:_____ DOB: ____/____/_____

SSN:_____ Tel. (____)_____-_____

Do you belong to a PPO? □ Yes □ No

PRIMARY MEDICAL INSURANCE

Employer:_____Primary Care:_____ Date of Last Exam:___/___/_____

Ins. Co.:_____ Address:_____

ID#:_____ Group#:_____ Tel. (___)____-_____

Primary Subscriber:_____Relation:_____ DOB: ____/____/_____ SSN:_____

Address:_____ Tel. (___)____-_____

HEALTH HISTORY

Chief dental concern:_____

Have there been any changes in your general health in the past year? □ Yes □ No

Physician's name:_____ Phone: (____)_____-_____ Location: _____

Does your physician require antibiotic pre-medication for dental procedures? □ Yes □ No

Do you have a prosthetic joint? □ Yes □ No Where?: _____

Do you have a history of prosthetic joint infection(s)? □ Yes □ No

Do you have a history of endocarditis? □ Yes □ No

Check only if you **HAVE** or have **HAD** any of the following:

High/low blood pressure	◯	Thyroid condition	◯
Cardiovascular condition	◯	Diabetes / high/low blood sugar	◯
High cholesterol	◯	Kidney disorder*	◯
Cardiac pacemaker/defibrillator	◯	* If **yes**, are you on dialysis? ○ Yes ○ No	
Heart valve replacement or vascular graft	◯	Arthritis / joint disease	◯
Heart surgery	◯	Osteoporosis / osteopenia	◯
Heart attack(s)	◯	Osteonecrosis	◯
Stroke	◯	Use of bisphosphonates (e.g. Actonel, Fosamax)	◯
Pulmonary (lung) issues	◯	Chronic pain / pain management	◯
Difficulty breathing/shortness of breath	◯	Acid reflux / stomach/esophageal ulcers	◯
Asthma	◯	Sexually transmitted disease(s)	◯
Sinus issues	◯	HIV / AIDS	◯
Snoring / sleep apnea*	◯	Compromised immune system	◯
* If **yes**, do you use a CPAP/snore device?	○ Yes ○ No	Slow healing from wounds	◯
Tuberculosis	◯	Recurrent growths/sore areas in/around mouth	◯
Tobacco use?	◯	A tumor or cyst(s)	◯
Blood disorder such as anemia	◯	Cancer	◯
Bleed / bruise easily	◯	History of radiation or chemotherapy	◯
Liver disease / jaundice / hepatitis	◯	History of alcohol abuse	◯
Fainting spells	◯	History of drug abuse	◯
Epilepsy / convulsions	◯	Pain or clicking of jaws when eating	◯
Chronic fatigue	◯	Headaches or migraines*	◯
Anxiety / depression +	◯	* If **yes**, frequency: _____x week _____ x month	
History of mental illness +	◯	Use of nighttime mouthguard	◯

+ If **yes**, please describe: _____

_____

Medications (Rx, OTC, supplements):

_____

_____

_____

_____

_____

_____

_____

◯ **Check here if you are NOT taking any medications**

Allergies (meds, food, etc):

_____

_____

_____

_____

_____

_____

_____

◯ **Check here if you have NO KNOWN allergies**

WOMEN

Possibility of pregnancy? □ Yes □ No * If yes, Due Date:_____/_____/_____ Are you nursing? □ Yes □ No

Are you using a form of birth control? □ Yes □ No

** Antibiotics (such as penicillin) may alter the effectiveness of birth control pills.*

Consult your physician/gynecologist for assistance regarding other methods of birth control.

CONSENT FOR TREATMENT

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

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 of a poor outcome.

TREATMENT TO BE PROVIDED

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

* Crowns * Preventive Services *Examinations *Bridges *Restorations *Other

Patient or Parental Initials:_____

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 or Parental Initials:_____

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 teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

CONSENT TO BILL

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

Patient or Parental Initials:_____

Patient Signature:_____ Date:____/_____/_____

If patient is a minor, parental signature:_____ Date: _____/_____/_____

FINANCIAL POLICY

Payment is due and expected at the time of treatment and may be paid by the following methods:
Cash, personal check, credit card, Care Credit & Lending Tree.

We understand the value of insurance benefits and will assist you in obtaining your maximum dental benefits.

We will gladly process your insurance claim for you and will give you the estimated payment due from your insurance company. Our estimates are based on the information you have furnished to us on your insurance plan.

We are not part of your insurance contract, and we cannot guarantee what your insurance plan will pay. Any balance not paid by insurance will be the patient's responsibility, or in the case of a minor, that of the responsible party.

Pre-estimation of a procedure is done as a courtesy through our office. Any certification that is required by a patient's insurance carrier is ultimately the responsibility of the patient or the patient's parent or guardian.

Initial Payment - A deposit amount of 50% on major dental treatment (root canals, crowns, fixed bridges, dentures and veneers) is expected when treatment is started.

I understand the above policies and agree to any interest due, collection costs, and reasonable attorney fees involved with collection of my account. I also understand that if I fail or cancel an appointment with less than 48 hours' notice, and this occurs 3 times within a 1 (one) year period, it will be assumed that North Country Dental cannot meet my scheduling needs and that it would be in my best interest to find another provider. I also understand that if I fail to show for a reserved appointment time without prior notification, I will be charged $40.00 - $100.00.

*We request 48 hours' notice when an appointment needs to be changed.

Patient Signature:_____ Date:____/_____/_____

If patient is a minor, parental signature:_____ Date: _____/_____/_____

HIPAA ACKNOWLEDGEMENT

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

**** You may refuse to sign this acknowledgment ****

Signature:_____ Date:____/____/_____

Notice of Privacy Practices

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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

We are required by law to maintain the privacy of your 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 in effect. This Notice takes effect July 23, 2013 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 in 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 of 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 and Public Benefit: 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 who may have been exposed to a disease or condition; 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 of 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 boa rd 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.

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 to you 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 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 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.

Contact Officer: Allison White Telephone: 603-466-5015 Fax: 603-466-5791 Email: dr2th@ncdnh.com
Address: North Country Dental, 22 Exchange Street, Gorham, NH 03581

Updated 7-23-2013

Please check off any of the following services which you would like to discuss or receive more information on:

Office Services

- □ Financial Consult
- □ Third Party Financing
- □ Insurance Processing
- □ Electronic Records
- □ Text, E-mail, and Phone Confirmations
- □ Personal Access to Digital Images
- □ Appointments & Account Balance

Hygiene Services

- □ Desensitizing Treatment
- □ Oral Hygiene Instruction
- □ Caries Risk Assessment Management
- □ Dental Hygiene & Periodontal Maintenance
- □ Fluoride Treatments
- □ Tobacco Counseling
- □ Nutrition Counseling
- □ Periodontal Scaling & Root Planing

Sealants

Doctor Services

- □ Implants
- □ Consults & Second Opinions
- □ Oral Cancer Screening
- □ Composite Fillings
- □ Extractions/Oral Surgery
- □ Bridges & Crowns
- □ CEREC Technology
- □ Dentures & Partials
- □ Veneers
- □ Cosmetic Bonding
- □ Advanced Periodontal Services
- □ Periodontal Surgery
- □ Root Canals
- □ TMJ/TMD Treatments
- □ Custom Night Guards
- □ Sports Mouth Guards
- □ Trauma Treatment
- □ 3D Imaging & Digital X-Ray
- □ Saliva & Bacterial Testing
- □ Hospital Based Dentistry
- □ Treatment Planning

Cosmetic Services

- □ Pelleve
- □ PCA Peels
- □ PCA Skin Care Products

Botox

- □ - Cosmetic
- □ - Headaches
- □ - TMJ
- □ □ - Sweating

Whitening

- □ - In-Office Treatment
- □ □ - Home Options

Orthodontic Services

- □ - Invisalign
- □ □ - Tri-Plex Quick Movement Retainers

Snoring & Sleep Apnea Bite Guards

North Country Dental
NEW HAMPSHIRE'S DENTIST

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 North Country Dental to use and disclose the protected health information described below to: _____. This person's relationship to me is:

□ Spouse/partner
□ Parent/guardian
□ Child
□ Other: _____

2. Effective Period

This authorization for release of information covers the period of care (choose one):
□ all past, present, and future periods **OR** □ from: _____to: _____

This information may be used by the person I authorize to receive this information for treatment, consultation, billing, claims payment, or other purposes as I may direct. This authorization shall be in force and effect unless revoked in writing. 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. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. 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.

_____

Signature of patient (or personal representative)

_____

Printed name of patient (or personal representative and his/her relationship to patient)

_____

Date