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PATIENT INFORMATION

Patient's Name ______________________________ Birthdate ____________________

Who referred you to this office ____________________ Social Security # ________________ Today's Date __________

Address ______________________________ City ____________________ ST_____ ZIP ____________

Home Phone ________________________ Work Phone ________________________ Ext ______________

Cell Phone ______________________ E-Mail ____

Employer______________________________ City ________________ Occupation ____________________

Name of Parent /Partner/ Spouse / Guardian______________________________ Birthdate _________________
(circle one) Social Security #______________________________

Address if different ______________________________ City ____________ ST ______ZIP ________________

Home Phone____________________________ Work Phone ____________________ Ext_______________

Employer ______________________________City ___________________ Occupation __________________

In case of emergency, whom shall we notify?

Name_____________________________Relationship _______________Phone _____________________________

PRIMARY DENTAL INSURANCE	**SECONDARY DENTAL INSURANCE**
EMPLOYEE NAME ______________________	EMPLOYEE NAME ______________________
INS CO NAME ______________________	INS CO NAME ______________________
INSURANCE PHONE______________________	INSURANCE PHONE______________________
GROUP / POLICY # ______________________	GROUP / POLICY # ______________________
SUBSCRIBER ID #______________________	SUBSCRIBER ID #______________________
SUBSCRIBER BIRTHDATE__________________	SUBSCRIBER BIRTHDATE__________________

Patient Acknowledgments:

- I understand that all charges incurred are **payable in full at the time of service**.
- I consent to the taking of radiographs and/or photographs before and during treatment for diagnostic purposes and for the use by the same dentist in scientific papers or demonstrations.
- I consent to the publication of my photos released to Dr. Maragliano-Muniz by any other healthcare providers.
- I certify that I have read (or had read to me), understand and agree to the contents of this form.

I have read the above: Signature ____ Date ______________________
Parent or Guardian if a minor

MEDICAL HISTORY FORM

PATIENT'S NAME: ______________________________ **DATE OF BIRTH:** ______________________

PHYSICIAN'S NAME: ____ **PHONE:** _________________

PHYSICIAN'S ADDRESS: ____

DATE OF LAST PHYSICAL: ____

Are you under the care of a recent or ongoing medical condition? ___________________________

If yes, please explain: ____

Have you ever been hospitalized or had a major operation within the last year? ________________

If yes, please explain: ____

Have you had any serious medical issues associated with any dental treatment? _______________

If yes, please explain: ____

Have you been advised to take antibiotics before a dental appointment? ______________________

If yes, please explain: ____

<u>CURRENT MEDICATIONS and DOSAGE INCLUDING OVER THE COUNTER AND HERBAL:</u>

____
____
____
____
____
____
____
____

<u>ALLERGIES</u>: Are you allergic to any drugs, food, environment, animals? Please explain:

____
____
____
____

<u>NOTES SECTION FOR SALEM DENTAL ARTS:</u>

____
____
____
____

PLEASE CHECK IF YOU HAVE HAD or HAVE ANY OF THE FOLLOWING CONDITIONS:

__ AIDS/HIV POSITIVE
__ ALZHEIMER'S DISEASE
__ ANAPHYLAXIS
__ ANEMIA
__ ARTHRITIS
__ ARTIFICIAL HEART VALVE
__ ARTIFICIAL JOINT
__ ASTHMA
__ BLOOD DISEASE
__ BLOOD TRANSFUSION
__ BREATHING PROBLEMS
__ BRUISE EASILY
__ CANCER
__ CHEMOTHERAPY
__ CHEST PAINS
__ COLD SORES
__ CONGENIAL HEART D.
__ DIABETES
__ DRUG ADDICTION
__ EMPHYSEMA
__ EPILEPSY or SEIZURES
__ EXCESSIVE THIRST
__ FAINTING SPELLS/DIZZINESS
__ FREQUENT COUGH
__ FREQUENT HEADACHES
__ GLAUCOMA
__ HAY FEVER
__ HEART ATTACK/FAILURE
__ HEART MURMUR
__ HEART PACEMAKER
__ HEART TROUBLE//DISEASE
__ HEMOPHILIA
__ HEPATITIS A
__ HEPATITIS B or C
__ HIGH BLOOD PRESSURE
__ HIGH CHOLESTEROL
__ HYPOGLYCEMIA
__ KIDNEY PROBLEMS
__ LEUKEMIA
__ LIVER DISEASE
__ LEUKEMIA
__ LIVER DISEASE
__ LOW BLOOD PRESSURE
__ LUNG DISEASE
__ M.VALVE PROLAPSE
__ OSTEOPOROSIS:SEE BELOW
__ HISTORY OF TAKING BISPHOSPHONATES IV/ORAL
__ PSYCHIATRIC CARE
__ RADIATION TREATMENTS
__ RECENT WEIGHT LOSS
__ RENAL DIALYSIS
__ RHEUMATIC FEVER
__ RHEUMATISM
__ SCARLET FEVER
__ SHINGLES
__ SINUS TROUBLE
__ STOMACH /INTESTINAL D.
__ STROKE
__ THYROID DISEASE
__ TUBERCULOSIS
__ TUMORS or GROWTHS
__ ULCERS
__ OTHER: FILL IN BELOW

____

____

Do you have any disease, condition or medical problem not listed you feel we should know?

Please explain:

____

____

____

____

DENTAL HISTORY

What is your chief complaint concerning your mouth or teeth?

____

____

Have you had any serious trouble associated with any previous dental treatment? _____________

If yes, please explain: ____

Have you had any undesirable reaction to local or general anesthetics? ______________________

If yes, please explain: ____

Are you dissatisfied with the appearance of your teeth? ___________________________________

If yes, please explain: ____

Do you clench or grind your teeth? ____

If yes, please explain: ____

Do you have pain in the face, cheeks, jaw, throat or temples? ______________________________

If yes, please explain: ____

Are your teeth sensitive to cold, hot or sweets? ____

If yes, please explain: ____

Do you have bleeding gums? ____

If yes, please explain: ____

Do you gag easily? ____

If yes, please explain: ____

Is there any other information you would like to share with Salem Dental Arts concerning your care? Please explain: ____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: ______________________________ ***Date:*** __________

Reviewed by Signature: ____ ***Date:*** _________

STANDARD OF CARE AND CONSENT TO TREATMENT

Dear Patient,

At Salem Dental Arts we have a ***Standard of Care*** that permits us to convey and promote the knowledge, value, practice, and behavior that support and enhance oral health. Dental hygiene is the discipline of the recognition, prevention and treatment of oral diseases and conditions as an integral component of total health. The dental hygiene diagnosis requires evidence-based, clinical assessment and interpretation of several components in order to reach conclusions about your dental hygiene and treatment needs.

Components of the clinical assessment include an examination of the head and neck and oral cavity including an oral cancer screening, periodontal charting, documentation of normal or abnormal findings, and assessment of the tempromandibular function. A *current and complete* set of radiographs every three (3) to five (5) years, and bitewing radiographs every year, provides needed data for a comprehensive dental and periodontal assessment. Sometimes additional radiographs are recommended on an as needed basis. A comprehensive periodontal examination every six months is also part of clinical assessment.

Failure to abide by these standards could result in the deterioration of your dental health.

CONSENT

I understand that all treatment options for my dental condition will be fully explained to me prior to beginning treatment. It is my responsibility to complete treatment and follow recommended maintenance schedules. If I do not proceed with my treatment plan in a timely manner, if maintenance plans are not followed and/or appointments are missed, adverse results could affect my dental health. Further treatment for the involved teeth, supporting tissues, adjacent and opposing teeth, muscles or joints will be based on standard professional office fees.

TREATMENT FEES

Fees are *estimates only*, are valid for **6 months** from the date given and are subject to revision. Treatment could be altered if my dental needs change. I will be notified of any change(s) in treatment.

ESTIMATED INSURANCE COVERAGE

Estimated insurance coverage is an *estimate only*, not a guarantee of payment or benefits. I understand that I will be responsible for insurance claims not paid within 60 days of service. We will gladly prepare and submit claims and documentation to assist you in obtaining maximum benefits available. However, the dentist's treatment recommendations and/or fees are based on your *dental needs and desires,* and are not a reflection of your dental benefits. Your dental benefits are a contract between you, your employer and the insurance company; therefore we only confirm insurance eligibility or submit predeterminations for recommended treatment for in-network insurance companies.

ACKNOWLEDGEMENT

I promise to pay for any time, materials and laboratory expenses incurred in my behalf. I further understand that any balance over 60 days past due may be subject to a finance charge and that I may be liable for any and all fees incurred in collecting a delinquent balance. In the event the balance on your account becomes more than 60 days overdue, billing may be turned over to an outside collection agency. The responsible party listed above agrees to pay *interest, collection and other legal expenses* related to collection of fees owed. Waiver of any breach of any time or condition shall not constitute a waiver of any further term or condition.

____
Patient
Initials

CANCELLATION POLICY

In an effort to avoid any misunderstandings, we would like to review our financial and office policies before you begin treatment in our office.

We reserve appointment times specifically for each patient so that we may provide the ultimate in service. It is important for you to keep the scheduled dates and times to properly complete your treatment. Please schedule your appointment carefully, as there may be a $ 50 fee assessed to your account for any appointment cancelled without **48 hours** notice. A missed appointment, an appointment when there is ***no*** cancellation notice received and the patient fails to show up for the scheduled appointment, may also be assessed a $50 fee. A broken appointment is a loss to three people: the patient who missed the valuable time, the patient who could have taken the valuable time; and the doctor who was fully staffed and prepared for the appointment. Similarly, late arrivals can create scheduling issues with other appointments. Please notify us if you are going to be late.

Please be advised that after three (3) cancellations or two (2) missed appointments, the patient may be requested to make same-day appointments only, to avoid fees to the patient and loss to the company.

***Note*:** All cancellation fees must be paid prior to scheduling another appointment.

I have read and understood in entirety the above:

PATIENT NAME: ____ **DATE:** ________________

SIGNATURE: ____
(Parent or Guardian if Patient is a Minor)

SDA WITNESS: ____ **DATE:** ______________

SIGNATURE: ____

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the professional office of my dentist named above to release health information identifying me under the following terms and conditions:

1. Detailed description of the information to be released: Release of models, radiographs, photographs and/or clinical findings.

2. To whom may the information be released: Dental/medical specialists that you may be referred to (eg. Periodontist, Orthodontist, Oral Surgeon, ENT, PCP, Dental Laboratory).

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state “at the request of the individual” as the purpose, if desired by the individual): Information would only be moved as necessary as communication for optimal care.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke

is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality, in many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

SIGNATURE: ____ **DATE:** _______________

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by the law to give you notice of our privacy practices. This Notice describes how we protect your heath information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: set up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose you health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" means those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organization that handle organ or tissue donation;
- Uses or disclosures for health related research;
- Uses and disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;

- disclosures of a “limited data set” for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to “business associates” who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written “authorization form.” The content of an “authorization form” is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it’s your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using email to your person email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- Ask us to see or to get photocopies of your health information. By law there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing or the extension. If you want to ask us to

amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or email shown at the beginning of this Notice.

- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment, or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this Notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or email shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the Notice of Privacy Practices.

______________________	______________________	__________
Name (print)	Signature	Date
______________________	______________________	__________
Witness	Signature	Date