

# Adult Pre-Clinical History

*The benefits of a healthy smile are immeasurable, and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete these forms so that we can provide the best care possible for you. Thank you!*

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## ABOUT YOU (Please Print Legibly)

Name: Last: \_\_\_\_\_ MI: \_\_\_\_\_ First: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Wk. Phone: \_\_\_\_\_ ext: \_\_\_\_\_

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer: \_\_\_\_\_

\*E-mail Address: \_\_\_\_\_

**\*(Used for Communication ONLY. We confirm patient reservations via email and texting.)\***

Who Can We Thank For Referring You To Our Office: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_ PH# \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ PH#: \_\_\_\_\_

## Responsible Party/Billing Information (If Same as Above, Please Indicate Here: SELF)

Name: Last: \_\_\_\_\_ MI: \_\_\_\_\_ First: \_\_\_\_\_ Relation to Pt: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I (Patient Name): \_\_\_\_\_ hereby authorize *Modern Dentistry of New England* to administer any treatment and to perform such as X-rays, anesthetics, and dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results. **I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that I am responsible for any costs that my insurance medical or dental does not cover.** My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**INSURANCE INFORMATION** (Please give the front desk your cards so that we may make a copy)

**PRIMARY DENTAL INSURANCE**

Policy Subscriber Name: \_\_\_\_\_

Policy Subscriber Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Dental Ins. Co. Name: \_\_\_\_\_

Policy ID# or SS#: \_\_\_\_\_

Relationship to Subscriber:    Self    Spouse    Parent    Other

Employer Name: \_\_\_\_\_

Group#: \_\_\_\_\_

**SECONDARY DENTAL INSURANCE (If applicable)**

Policy Subscriber Name: \_\_\_\_\_

Policy Subscriber Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Dental Ins. Co. Name: \_\_\_\_\_

Policy ID# or SS#: \_\_\_\_\_

Relationship to Subscriber:    Self    Spouse    Parent    Other

Employer Name: \_\_\_\_\_

Group#: \_\_\_\_\_

**MEDICAL INSURANCE COVERAGE**

Policy Subscriber Name: \_\_\_\_\_

Policy Subscriber Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Medical Insurance Company Name: \_\_\_\_\_

Policy ID# or SS#: \_\_\_\_\_

Relationship to Subscriber:    Self    Spouse    Parent    Other

Employer: \_\_\_\_\_

Group#: \_\_\_\_\_

Is this an insurance Policy from your Employer Past or Present?  YES     NO

Is this a Medicare Policy or supplement?     YES     NO

Did you purchase this insurance through *Affordable Care Act?* (ObamaCare)     YES     NO

# Health History Form

Email: \_\_\_\_\_ Today's Date: \_\_\_\_\_

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: <i>Last First Middle</i>			Home Phone: <i>Include area code</i> ( )	Business/Cell Phone: <i>Include area code</i> ( )	
Address: <i>Mailing address</i>			City:	State:	Zip:
Occupation:	<b>Height:</b>	<b>Weight:</b>	Date of Birth:	Sex: M F	
SS# or Patient ID:	Emergency Contact:	Relationship:	Home Phone: <i>Include area code</i> ( )	Cell Phone: <i>Include area code</i> ( )	
If you are completing this form for another person, what is your relationship to that person?					
<i>Your Name</i>			<i>Relationship</i>		
<b>Do you have any of the following diseases or problems:</b>			<i>(Check DK if you Don't Know the answer to the question)</i>		<b>Yes No DK</b>
Active Tuberculosis.....					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Persistent cough greater than a 3 week duration.....					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cough that produces blood.....					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Been exposed to anyone with tuberculosis.....					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.</b>					

## Dental Information *Please mark (X) your responses to the following questions.*

Yes No DK		Yes No DK	
Do your gums bleed when you brush or floss?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have earaches or neck pains?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure? .....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw? .....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your mouth dry?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you brux or grind your teeth?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any periodontal (gum) treatments? .....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have sores or ulcers in your mouth?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you ever had orthodontic (braces) treatment? .....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you wear dentures or partials? .....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any problems associated with previous dental treatment? .....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you participate in active recreational activities?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your home water supply fluoridated?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you ever had a serious injury to your head or mouth? .....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you drink bottled or filtered water?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of your last dental exam:	
If yes, how often? <i>(Check one):</i> DAILY <input type="checkbox"/> / WEEKLY <input type="checkbox"/> / OCCASIONALLY <input type="checkbox"/>		What was done at that time?	
Are you currently experiencing dental pain or discomfort?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of last dental x-rays:	
What is the reason for your dental visit today?			
How do you feel about your smile?			

## Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

Yes No DK		Yes No DK	
Are you now under the care of a physician? .....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Physician Name: _____	Phone: <i>Include area code</i> ( )	If yes, what was the illness or problem?	
Address/City/State/Zip:		Are you taking or have you recently taken any prescription or over the counter medicine(s)?.....	
Are you in good health? .....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:	
Has there been any change in your general health within the past year? .....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	
If yes, what condition is being treated?		_____	
Date of last physical exam:		_____	

# Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

<p><i>(Check DK if you Don't Know the answer to the question)</i></p> <p>Do you wear contact lenses? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><b>Joint Replacement.</b> Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date: _____ If yes, have you had any complications? _____</p> <p>Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date Treatment began: _____</p>	<p style="text-align: right;"><b>Yes No DK</b></p> <p>Do you use controlled substances (drugs)? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you use tobacco (smoking, snuff, chew, bidis)? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If so, how interested are you in stopping? <i>Circle one: VERY / SOMEWHAT / NOT INTERESTED</i></p> <p>Do you drink alcoholic beverages? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, how much alcohol did you drink in the last 24 hours? _____</p> <p>If yes, how much do you typically drink in a week? _____</p> <p><b>WOMEN ONLY</b> Are you:</p> <p>Pregnant? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Number of weeks: _____</p> <p>Taking birth control pills or hormonal replacement? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Nursing? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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<p><b>Allergies.</b> Are you allergic to or have you had a reaction to: To all <b>yes</b> responses, specify type of reaction.</p> <p>Local anesthetics ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Aspirin ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Penicillin or other antibiotics ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Barbiturates, sedatives, or sleeping pills ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sulfa drugs ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Cocaine or other narcotics ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;"><b>Yes No DK</b></p> <p>Metals ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Latex (rubber) ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Iodine ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hay fever/seasonal ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Animals ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Food ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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**Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.**

<p style="text-align: right;"><b>Yes No DK</b></p> <p>Artificial (prosthetic) heart valve ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Previous infective endocarditis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged valves in transplanted heart ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congenital heart disease (CHD)</p> <p style="padding-left: 20px;">Unrepaired, cyanotic CHD ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Repaired (completely) in last 6 months ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Repaired CHD with residual defects ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;"><b>Yes No DK</b></p> <p>Autoimmune disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatoid arthritis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Systemic lupus erythematosus ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Asthma ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Bronchitis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Emphysema ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sinus trouble ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Tuberculosis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Cancer/Chemotherapy/ Radiation Treatment ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chest pain upon exertion ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chronic pain ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Diabetes Type I or II ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Eating disorder ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Malnutrition ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Gastrointestinal disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>G.E. Reflux/persistent heartburn ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Ulcers ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Thyroid problems ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Stroke ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;"><b>Yes No DK</b></p> <p>Glaucoma ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hepatitis, jaundice or liver disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Epilepsy ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Fainting spells or seizures ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Neurological disorders ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, specify: _____</p> <p>Sleep disorder ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you snore? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Mental health disorders ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Specify: _____</p> <p>Recurrent Infections ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Type of infection: _____</p> <p>Kidney problems ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Night sweats ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Osteoporosis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Persistent swollen glands in neck ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe headaches/ migraines ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe or rapid weight loss ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sexually transmitted disease .. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Excessive urination ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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*Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.*

<p style="text-align: right;"><b>Yes No DK</b></p> <p>Cardiovascular disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Angina ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arteriosclerosis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congestive heart failure ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged heart valves ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart attack ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart murmur ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Low blood pressure ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>High blood pressure ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other congenital heart defects ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;"><b>Yes No DK</b></p> <p>Mitral valve prolapse ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Pacemaker ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic fever ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic heart disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Abnormal bleeding ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Anemia ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Blood transfusion ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, date: _____</p> <p>Hemophilia ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>AIDS or HIV infection ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arthritis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? .....

Name of physician or dentist making recommendation: \_\_\_\_\_ Phone: *Include area code*  
(    )

Do you have any disease, condition, or problem not listed above that you think I should know about? .....

Please explain: \_\_\_\_\_

**NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Dentist: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR COMPLETION BY DENTIST**

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Late, Cancellation and Missed Appointment Contract**

**for Modern Dentistry of New England**

We certainly understand that occasionally circumstances arise that prevent patients from keeping appointments. **However, our office requires a 48 hour notice for proper cancellation or rescheduling of appointments. A missed, no show or appointment cancellation without a 48 hour notice will be charged a \$25 fee. *Saturday appointments* have a \$50.00 fee. This fee must be paid, before any future appointments will be given.**

We view our appointment times as a *commitment* that we will be here to serve you, and you will be present for that appointment. Without a 48 hour notice, we cannot give that appointment opportunity to someone else who needs it. Also, we request this courtesy because it allows us to see our patients promptly and helps us provide more affordable dental care for all of our patients.

As a courtesy, we send out hygiene reminder cards, email reminders, text messages and/or provide a phone call prior to the appointment you have scheduled. ***Again, these reminders are a courtesy.*** If for some reason you do not receive these reminders, your appointment is still ***your responsibility*** and the **charges will still apply if the appointment is not kept or cancelled properly.**

Thank you, in advance, for your cooperation. Having understanding patients enables us to better serve the needs of our patients.

***\*\*We require confirmation of appointments. We make every effort to contact you via Email, text or phone. Please do us the courtesy to respond to our attempts.\*\****

***For any appointment made that is over 90 minutes long, our office requires an appointment reservation deposit of 50% of your estimated copay. That will be applied toward payment of your dental treatment. The Balance is due upon your treatment appointment date.***

I, \_\_\_\_\_ have read and understand the above Statement.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_/\_\_/\_\_

## Modern Dentistry of New England Financial Policy /Agreement

We are committed to providing you with the highest quality of dental care utilizing only the best materials and technology available. In our efforts to do so, we have formulated the following financial policy. We value our patients and have worked hard to provide several options to meet your needs. **Please read this policy carefully!**

Many patients have a commonly held misconception that medical and dental benefit policies that their employer, or they individually, have purchased will pay for all of their treatment. THAT IS INCORRECT AND UNTRUE.

**Financial responsibility for all services received at this office regardless of insurance coverage is yours alone.**

**Modern Dentistry of New England** is happy to partner with our patients who are covered by dental/medical insurance, by billing the insurance for you. However, it is **your responsibility** to inform us when your policy changes so we can bill the correct carrier. We ask that **YOU read your policy thoroughly** so that you are fully aware of the benefits provided and the limitations imposed. Please call your insurance company if you have any questions concerning your plan. Please understand that our responsibility is to provide you with **Superior Dental Care** and the treatment that best meets your needs, not on what your dental insurance policy covers. It is our goal for patients to clearly understand their treatment needs as well as their financial responsibility before treatment begins. Estimated patient portions are due at time of service. We do our best to **estimate** your patient portion prior to your appointment. These estimates are based on the outline given by your insurance plan. **Please note that these are estimates only. As stated by all insurances companies, there is not a guarantee of payment until the actual claim is processed. Due to policy differences and clauses you may owe more than we estimate. Disputes regarding reimbursement or the amount of reimbursement are between you and your insurance carrier.** If your insurance company pays more than the estimate we will issue a prompt refund via check.

**\*Medical Insurance Company Billing,** Will be discussed on an **individual basis** with each patient, and a separate financial responsibility contract will need to be signed.

\*Outstanding insurance claims over 90 days, become the patient's responsibility. All incurred charges are ultimately the responsibility of the patient.

We are unable to carry "patient" balances over 90 days in the office. . Therefore, all overdue balances of 90 days or more are sent out of the office for collection. We dislike doing this and will do so only if all other efforts to collect your unpaid balance have failed. Once an account is turned over to collections, we will ask you to seek the services of another dentist and will no longer take responsibility for your family's dental care

**PAYMENT OPTIONS:** We are pleased to offer 3 payment options for our patients:

1. We gladly accept Cash, Check (25.00 return check fee) Visa, MasterCard and American Express for your convenience.
2. Care Credit & Lending Point: Are special No interest financing options provided by our Office.
3. *Limited in house financing on certain types of treatment: ½ at start of treatment with balance due upon completion.*

**I HAVE READ THE ABOVE FINANCIAL RESONSIBILITY STATEMENT AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO Dr.Gabr Modern Dentistry of New England FOR ALL CARE AND SERVICES PROVIDED TO ME.**

Patient/Guardian Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

**SIGNATURE RELEASE STATEMENT/ASSIGNMENT OF BENEFITS**

**YOUR SIGNATURE IS NECESSARY FOR US TO:**

- 1. PROCESS ALL INSURANCE COMPANY CLAIMS**
- 2. ENSURE PAYMENT FOR SERVICES PROVIDED**
- 3. RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS**
- 4. RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS INCLUDING, LABORATORIES, WHEN NECESSARY, FOR YOUR TREATMENT**

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as labs that need my information to make a diagnosis, or fabricate an appliance necessary for my treatment.

I assign all Medical / Dental and Surgical benefits, including major medical benefits to which I am entitled, to Sherif Gabr D.M.D. Modern Dentistry of New England. This Assignment will remain in effect until revoked by me in writing. A photocopy if this assignment is to be considered as valid as the original.

**Patient Signature:** \_\_\_\_\_

**Patient Full Name (Printed):** \_\_\_\_\_

**Parent Signature if Patient is a minor:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

**Date Signed:** \_\_\_\_/\_\_\_\_/\_\_\_\_

# Notice of Privacy Practices

## Sherif Gabr D.D.S – DBA Modern Dentistry of New England

*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.*

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose such information. Without specific authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

Unless you request otherwise, we may use or disclose your health information to a family member, friend or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and leaving messages at your home or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights:

- The right to request restrictions on certain uses and disclosures of protected health information. We are however, not required to agree to a requested restriction. If we do agree, we must abide by it.
- The right to request to receive confidential communications of protected health information by alternative means or at alternative locations.
- The right to access, inspect and copy your protected health information.
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information, outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this agreement upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. You have the right to file a formal complaint with us or with the Department of health & Human Services, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint. For more information about HIPAA or to file a complaint, please contact: The U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue S.W., Washington D.C. 20201, (877) 696-6775 For more information about our Privacy Practices, please contact: Modern Dentistry of New England 225 N. Main St. Bristol CT 06010 (860)582-4485

**\*This page is for your records.\***



# Acknowledgement of Receipt of Notice of Privacy Practices

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I have received a copy of Modern Dentistry of New England's Notice of Privacy Practices. I acknowledge that I have had the full opportunity to read the Notice of Privacy Practices.

(\*Please note: you may refuse to sign this acknowledgment.)

**Patient Name:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

***If patient is under 18, Patient's Parent or Guardian/ Relationship to patient***

**Signature:** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

\*\*HIPAA requires health care providers to protect the privacy of your health information. However, if you don't object, a health care provider or health plan may share relevant information with family members or friends involved in your health care or payment for your health care.

I give Modern Dentistry of New England permission to speak to:

**Name:** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

<b>FOR OFFICE USE ONLY</b>
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<b>Where Responsible Party/Parent/ Legal Guardian Does NOT Sign.</b>
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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- \_\_\_ Individual refused to sign
- \_\_\_ Communication barriers prohibited obtaining the acknowledgment
- \_\_\_ Emergency situation prevented us from obtaining acknowledgement
- \_\_\_ Other (Please Specify) \_\_\_\_\_

Modern Dentistry Staff Signature: \_\_\_\_\_