All Dental ° 76 Otis Street ° Westborough, MA 01581

Date:_____ Primary Care Physician:_____

SSN:_____ Physician Phone:_____

Patient Information

Patient Name:_____ _____
Last First

Address:_____

City:_____ State:_____ Zip:_____

Birthday:___/___/___ Employer:_____ Occupation:_____

Spouse's Name:_____ _____
Last First

Birthday:___/___/___ Employer:_____ Occupation:_____

Phone Numbers/E-mail

Home: (____)_____ Work: (____)_____ext___ Cell:(____) _____

Email:_____

IN CASE OF AN EMERGENCY WHO MAY WE CONTACT (SPECIFY SOMEONE WHO DOES NOT LIVE IN YOUR HOUSE)

Name:_____ Relationship:_____

Home Phone:(____)_____ Work/Cell:(____)_____

Dental Insurance:

Subscriber Name:_____ SSN/ID#:_____

DOB:_____/_____/_____ Insurance Company:_____

Employer Name:_____ Group#:_____

What is your reason for this dental visit:_____

_____

_____

Patient Signature:_____ Date:____/____/_____

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HEALTH HISTORY

Do you have or have you had any of the following problems?
PLEASE CHECK OFF ALL BOXES

	Yes	No		Yes	No		Yes	No
AIDS/HIV			Epilepsy			Radiation Treatment		
Anemia			Fainting or dizziness			Respiratory Disease		
Arthritis, Rheumatism			Unexplained weight loss			Rheumatic Fever		
Artificial Heart Valves			Headaches			Scarlet Fever		
Artificial joints			Heart Murmur			Shortness of Breath		
Asthma			Heart Problems			Sinus Problems		
Psychiatric Care			Hepatitis Type____			Skin Rash		
Bleeding Abnormally			Herpes			Venereal Disease		
Blood Disease			High Blood Pressure			Stroke		
Cancer			Jaundice			Swollen Feet or Ankles		
Chemical Dependency			Jaw Pain			Swollen neck glands		
Chemotherapy			Kidney Disease			Thyroid Problems		
Circulatory Problems			Liver Disease			Tonsillitis		
Congenital Heart Lesion			Low Blood Pressure			Tuberculosis		
Cortisone Treatments			Mitral Valve Prolapsed			Tumor or growth of head /neck		
Diabetes			Nervous Problems			Ulcer		
Emphysema			Pacemaker			Women: are you pregnant?		

Have you had any surgeries within the past year? _____ If yes please describe:

_____

Allergies: (Please check any that apply)
·Codeine_____ ·Iodine _____ ·Sulfa _____· Latex _____ ·Penicillin: _____

OTHER: _____

Medications: (please Specify)

_____

_____

Current Address: _____

City:_____ State: _____ Zip: _____

Current Telephone Numbers:
Home: _____ Work: _____ Cell: _____

Email: _____

Patient Signature: _____ Date: ____/____/____

Printed Name: _____

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Financial Agreement

Thank you for choosing us as your dental health provider. We are committed to provide the highest quality of dental care and continued maintenance of your oral health. Please understand that paying for your dental work is considered to be an integral part of your ongoing treatment. The following is a statement of our *Financial Agreement* which we require you to read and sign prior to any treatment.

Full payment is due at the time of service. For your convenience we accept cash, checks, VISA, MasterCard, American Express and Discover. We also offer an extended payment plan through the independent credit companies with prior credit approval.

Regarding Dental Insurance

All co-pays and deductibles are due on the date of service. The balance is your responsibility whether your insurance company pays it or not. We cannot bill your insurance company unless you provide us with your insurance information and a copy of your insurance card or an original claim form at the time of service. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In an event that we do not accept assignment of benefits, we require that the service be pre-approved based on the benefits provided by your insurance carrier. If your insurance company has not paid the balance on your account in full within 90 days, that balance will automatically be transferred to your private balance or the extended payment plan if prior arrangements.

Minor Patients and Students

The adult accompanying a minor and the parents (or guardians of the minor or students) are responsible for full payment. For unaccompanied minors or students, non emergency treatment will not be provided unless the charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at the time service are rendered as well as the prior consent to the services to be provided for the minor.

Missed Appointments

Unless canceled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of **$50** per appointment. If emergency situation arises that prevents you from keeping your appointment please, let us know as soon as possible so we can reschedule your appointment. Please help us to serve you better by keeping your scheduled appointments.

Thank you for understanding our *Financial Agreement*. Please let us know if you have any questions or concerns. I have read the *Financial Agreement,* and I understand and agree to its terms and conditions.

_____ _____

Signature of Responsible Party Date

All Dental ° 76 Otis Street ° Westborough, MA 01581

How did you hear about us?
(Please check one)

Your name:_____

Date:_____

Insurance Company:

_____ Delta

_____ Guardian

_____ Fallon

Yellow Pages:

_____ Yellow Pages (BIG BOOK)

_____ Yellow Pages (SMALL BOOK)

Other:

_____ Our Website

_____ City Living Magazine

_____ Super Coupon

_____ RSVP Coupon (Postcard)

_____ ValuePak

_____ Walk-in

_____ T.V Ad

_____ Britesmile

_____ Russian Ad

_____ House mailing

_____ Referral – If so who may we thank for your referral to our office?

_____

All Dental ° 76 Otis Street ° Westborough, MA 01581

Acknowledgement of Receipt of Notice of Privacy Practices
You may refuse to sign this acknowledgement

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

_____
Print Your Name

_____
Signature

_____
Date

For Office Use Only

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

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify)

_____

_____

_____

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

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 03/01/2003 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. We reserve the right to make the changes in our privacy practices and the new terms of our new Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help your health with your healthcare or with payment for your healthcare, but only if you agree we do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on the determination using our professional judgment disclosing only health information tat is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.____ for each page. $___ per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency)

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make you request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location your request.

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.

Electronic Notice: If you receive this Notice on our web site or by electronic mail (e-mail) you are entitled to receive this Notice in written form.

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 complained to the U.S Department of Health and Human Services. We will provide you with the address to your complaint with the U.S Department of Health and Human Services.

Name:
Date:

How did you hear about us?
(Please check one)

Insurance Company:

_____ **Delta**

_____ **Guardian**

_____ **Fallon**

Yellow Pages:

_____ **Yellow Pages Big Book**

_____ **Yellow Pages Small Book**

Other:

_____ **Our Website**

_____ **City Living Magazine**

_____ **Solutions Direct (Postcard)**

_____ **SuperCoups**

_____ **Sedation Network**

_____ **ValuePak**

_____ **Walk-in**

_____ **BriteSmile**

_____ **Russian Ad**

_____ **House Mailing**

_____ **Referral- If so, who can we thank for your referral to our office?**

_____

Contact Officer: Katherine Libson; Privacy Officer: Dr. Andrey Mazo, DMD

Telephone: 508-870-1911

Fax: 888-672-9127

E-mail: MazoLender@charter.net

Address: 76 Otis Street, Westborough, MA 01581
