Coastal Dental Seekonk

21 Brook Street | STE 8 • Seekonk, MA 02771 (508)399-7073

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Preferred appointment times:

_____

_____

Pharmacy Name and Address

_____

_____

Employment Information

The following is for: ○ the patient ○ the person responsible for payment ○ both ○ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Responsible Party Information

The following is for: ○ the patient's spouse ○ the person responsible for payment ○ both ○ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Primary Insurance Information

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Secondary Insurance Information

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Response Date:
___/___/_____

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Medical & Dental History Form

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? ○ Yes ○ No

Within the past year, have there been any changes in your general health? ○ Yes ○ No

What was the date (or approximate date) of your last medical exam? _____

Your Primary Care Physician's name, address, & phone number:

_____

_____

Please mark any of the following to indicate YES in response to the question:

☐ Have you ever had complications following dental treatment?
☐ Are you currently under the care of a physician due to a specific condition?
☐ Have you been hospitalized within the last two years due to surgery or illness?
☐ Are you currently taking any prescription or non-prescription medications? List Below.
☐ Do you use tobacco? (smoking or chewing)
☐ Have you ever had a blood transfusion?
☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

WOMEN ONLY: Are you pregnant? ○ Yes ○ No

If any of the previous questions are marked, please explain:

_____

_____

Is Pre-med Antibiotic required prior to dental appointments? ○ Yes ○ No

If yes, please indicate Prescription name:

_____

_____

What is the reason for your dental visit today?

When was your last visit to the dentist, & what was performed?

How frequently do you brush your teeth?

○ 3(+) a day ○ Twice a day ○ Once a day ○ Weekly ○ Seldom

How frequently do you floss your teeth?

○ 1(+) a day ○ 2-6 weekly ○ 1-6 weekly ○ Seldom ○ Never

Please mark any of the following to indicate YES in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to hot or cold temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth? (consciously or during sleep)

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

Additional Notes:

List of Medications:

Do you have any other health issues or allergies?

_____

_____

_____

Please indicate if you have experienced any of the following:

☐ Allergy- Asprin	☐ Allergy- Clindamycin	☐ Allergy- Codeine
☐ Allergy- Drug	☐ Allergy- Erythromycin	☐ Allergy- Hay Fever
☐ Allergy- Latex	☐ Allergy- Metals	☐ Allergy- N-Saids
☐ Allergy- Other	☐ Allergy-Penicillin	☐ Allergy- Sulfa
☐ Anemia	☐ Angia	☐ Anxiety
☐ Arthritis	☐ Artificial Prosth.	☐ Asprin
☐ Asthma	☐ Biophosophonates	☐ Blood disease
☐ Blood Pressure-high	☐ Blood Pressure- low	☐ Blood Transfusion
☐ Cardiac Pacemaker	☐ Cancer	☐ Chest Pains
☐ Diabetes	☐ Easily Winded	☐ Epilepsy/Seizures
☐ Emphysema	☐ Excessive Bleeding	☐ Fainting/Diziness
☐ Freguently Tired	☐ Glaucoma	☐ Heart Attack
☐ Heart Bypass	☐ Heart Disease	☐ Heart Murmur
☐ Heart Trouble	☐ Hepititis	☐ High Cholesterol
☐ HIV-Pos/AIDS	☐ Immunosupressed	☐ Joint Replacement or Implant
☐ Kidney Disease	☐ Leukemia	☐ Liver Disease
☐ Low Platelets	☐ MEDS- Anticoag	☐ MEDS- BP
☐ MEDS- Dilantin	☐ MEDS-Other	☐ Other
☐ Pacemaker	☐ PREMED- Amox	☐ PREMED- Clinda
☐ PREMED- Erythromycin	☐ PREMED- Keflex	☐ PREMED- Other
☐ Psychiatric Care	☐ Radiation TX	☐ Recent Weight Loss
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Sinus Problems	☐ Stomach Problems	☐ Stroke
☐ Swollen Ankles	☐ Tuberculosis	☐ Thyroid Disorder
☐ Tumors	☐ Ulcers	☐ Xerostomia/Dry Mouth

If any of the previous questions are marked, please explain:

_____

_____

Signature_____ Date _____

Response Date:
___/___/_____

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Referral

Whom may we thank for referring you?

- ○ One of our valued patients (name of patient)_____
- ○ Mailing
- ○ Google Search
- ○ Drive-By
- ○ Our Web Site
- ○ Yelp
- ○ Other (please specify)

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilites with our practice.

Response Date:
____/____/_____

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Consent for Internet Communications

Patient Name: _____ _____ ___ _____

Last First MI Preferred Name

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Signature of patient, parent, or guardian:

Signature _____ **Date** _____

Relationship to Patient:

_____

_____

Response Date:

___/___/_____

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Acknowledgement of Receipt of Privacy Practices Notice

This document acknowledges that you have received a copy of: Notice of Privacy Practices

This document is not a contract, authorization, release, or consent form. This document will remain in your records.

☐ **From time to time we apprise our clients of events that may be of interest to them via email or mail. Please check here if you do NOT wish to be notified of such events.**

I _____, acknowledge that I have reviewed a copy of the Notice of Privacy Practices.

Signature _____ **Date** _____

Response Date:
___/___/_____

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Consent for Disclosure of Health Care Information

Patient Name: _____ _____ __ _____
Last First MI Preferred Name

In addition to sending postcards, I give Coastal Dental and staff permission to provide appointment reminders using: (Check all that apply)

☐ Voicemail ☐ Email _____ ☐ Answering Machine ☐ Cell Phone #

☐ Texting

Best Telephone # to contact me is

_____

_____

Emergency Contact: (Name, Phone #, Cell #)

_____

_____

I give Coastal Dental and staff permission to speak with the person (s) listed below regarding my dental and health care, including diagnosis, treatment, and payment for services rendered:

Name & Phone #

_____

_____

_____

Signature _____ **Date** _____

This Consent is valid until such time as I provide a written revocation of it.

Response Date:
___/___/_____

Coastal Dental Seekonk

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Authorization and Consent for Services

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I hereby authorize, and give my consent for Coastal Dental/staff to administer such medications and perform such diagnostic and dental treatments as may be necessary for proper dental care. I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being a root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

Patient's with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on assumption that our charges will be paid by an insurance company.

I authorize Coastal Dental to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners via email, fax, telephone, or internet. I authorize my insurance carrier to submit payment directly to Coastal Dental so it may be applied directly to my account.

I understand that I am financially responsiblefor any outstanding balance for services and materials provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered onmy behalf or on behalf of my dependents (if any).

A service charge of 1.5 per month (18 per annum) on the unpaid balance will be charged on all accounts exceeding 30 days.

I acknowledgel have recieved a copy of the Notice of Privacy Practices

Signature _____ **Date** _____

Response Date:
___/___/_____

COASTAL DENTAL SEEKONK NOTICE OF PRIVACY PRACTICES

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 PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 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 that 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 notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised 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 Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures of your protected healthcare information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that maybe made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your healthcare and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory)who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based On Your Written Authorization:Other uses and disclosures of your protected health information will be made only with your authorization,unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected 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. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process,under certain circumstances. Under limited circumstances,such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may

also request access by sending us a letter to the address at the end of this notice. If you request copies, you may incur a charge to locate and copy your protected 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 protected 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.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2009, the accounting will be provided for the past six(6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected 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). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location,and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain 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 using the information below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. 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 protect the privacy of your protected health information. We will not retaliate in anyway if you choose to file a complaint with us or with the U.S. Department of Health and Human Services

Name of Contact Person: Stacie Brito
Email: sbrito@coastaldentalgrp.com
Telephone: (508) 399-7073
Address: 21 Brook Street Suite 8, Seekonk, MA 02771