Your Dental History

Patient Name _____ **Date** _____

Primary reason for appointment today: □ Exam/Cleaning □ Consultation □ Emergency □ Other

Former Dentist _____ City, State _____

Date of last dental visit_____

Please tell us what you liked about your last dental experience_____

_____

Please tell us what you did not like about your last dental experience _____

_____

How often do you brush & floss? _____

Do You: □ Smoke □ Chew Tobacco □ Bite Nails □ Grind Teeth

Your Medical History

Primary Care Physician Name/Telephone #_____

Are you under the care of any other physicians? If so, please list name/telephone # _____

_____

Your current physical health is: □ Excellent □ Good □ Fair □ Poor

Have you ever had a serious injury/major operation? Discuss _____

Please list all medications/drugs you currently take (use back of this page for additional space)

_____

Are you allergic to any of the following? Please check below:

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex Rubber □ Other (see next question)

Please list any other allergies to medications/drugs you may have_____

Do you require pre-medication before dental visits?_____

Women (please check all that apply)**:** □ Pregnant/Trying □ Nursing □Taking Oral Contraceptives

Do you now have, or have you ever had any of the following? Please check appropriate boxes below

□ Heart Trouble/Disease	□ Anemia	□ Cancer	□ Artificial Joint
□ Mitral Valve Prolapse	□ Blood Disease	□ Radiation	□ Herpes/Cold Sores
□ Heart Murmur	□ Heart Surgery	□ Chemotherapy	□ Venereal Disease
□ Artificial Heart Valve	□ Hemophilia	□ Stomach/Intestinal Problems	□ HIV/AIDS
□ Rheumatic Fever	□ Sickle Cell Disease	□ Diabetes	□ Stroke
□ Heart Attack/Failure	□ Leukemia	□ Hepatitis/Liver Disease	□ Convulsions
□ Congenital Heart Disorder	□ Lung Disease	□ Kidney Problems/Dialysis	□ Epilepsy or Seizures
□ Irregular Heart Beat	□ Breathing Problems	□ Thyroid Disease	□ Glaucoma
□ Heart Pace Maker	□ Asthma	□ Parathyroid Disease	□ Tumors
□ High Blood Pressure	□ Emphysema	□ Arthritis/Gout	□ Hives or Rash
□ Low Blood Pressure	□ Tuberculosis	□ Rheumatism	□ Allergies
		□ Drug Addiction/Alcoholism	□ Psychiatric Care

Please indicate if you have any serious illnesses not listed above _____

Do you wish to speak to the dentist about any problems? _____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X_____ **Date** _____

Patient Signature (Parent or guardian)

Reviewed By Doctor _____ **Date**_____

Medical Updates on backside of this page

Medications

Drug Name	Treatment for	Dosage

Medical History Updates

Date	Changes	Patient's Signature	Reviewed by

Welcome to Our Practice!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs

About You

Date:_____ □ Male □ Female

Full Name:_____ (Nickname)_____

DOB: ____/____/____ Social Security # ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Home Address: _____ _____
Street Suite/Apt #

_____ _____ _____
City/Town State Zip

Home Phone # _____ Cell Phone# _____

Work Phone:_____ Email: _____

Employer:_____ If a student, name of school _____

If under 18, person responsible for account: _____

Emergency Contact: _____ _____
Name Telephone #

Whom may we thank for referring you? _____

Your Dental Insurance

Primary Dental Insurance Carrier Name _____

Named Subscriber on policy: _____

Subscriber ID Number: _____ Policy Group # _____

If you are NOT the subscriber, please answer the following:

Subscriber DOB: ____/____/____ Subscriber SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Relationship to you: _____

Subscriber Employer/Group Plan Name _____

If you have secondary dental insurance, please fill in below

Secondary Dental Insurance Carrier Name_____

Named Subscriber on Policy: _____

Subscriber ID #:_____ Policy Group # _____

Subscriber DOB: ____/____/____ Subscriber SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Relationship to you: _____

Subscriber's Employer/Group Plan Name: _____

The information on this page is correct to the best of my knowledge. I hereby authorize Waverley Dental Care to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. I hereby authorize Waverley Dental Care to submit my dental treatments to my insurance company for payment on my behalf. I grant the right to Waverley Dental Care to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X_____ _____
Signature of Patient or Responsible Party Date

Secondary Dental Insurance

Secondary Dental Insurance Carrier_____

Named Subscriber on policy: _____

Subscriber ID Number: _____

If you are NOT the subscriber, please answer the following:

Subscriber DOB: ____/____/____ Subscriber SS# _ _ _ - _ _ - _ _ _ _

Relationship to you: _____ Group # _____

Subscriber's Employer/Group Plan Name: _____

Waverley Dental Care

PAYMENT POLICY

Thank you for choosing Waverley Dental Care as your dental health care provider. We are committed to the success of your dental care and want to provide you with the best service possible. To help reduce our administrative costs and keep our fees to you as low as possible, ***Waverley Dental Care requires payments to be made at the time you receive treatment unless other financial arrangements have been made.*** We accept cash, check, and Visa/MasterCard.

Payment Plans

Waverley Dental Care is happy to offer a payment plan for treatment fees of $300 and up. Our finance plan will allow you to make payments over a period of months, and up to five years with no interest or low fixed interest terms. This plan is subject to approval (based on credit score). If you are interested in financing, arrangements must be made *before* treatment is rendered. Please see front desk for details.

For patients with dental insurance

Due to constant changes in insurance plans, it is not possible for us to interpret each individual policy. It is your responsibility to know your dental coverage and eligibility status. Having dental insurance is not a guarantee of payment. Most treatments carry a co-payment/deductible and many services are not covered at all. Based on the dental plan details available to us, we can ***estimate*** the amount of your co-payments to the best of our abilities, however, until a claim is formally processed, there is no guarantee. If your insurance company fails to pay your dental claim within 60 days you will be held responsible for the full amount.

Acceptance Agreement

- **I have read and understand the above financial policy**
- **I understand that I am responsible for payment on services that are not covered by my insurance company as well as co-pays and deductibles after insurance has paid its portion of covered services.**
- **I understand that the parent or guardian bringing a child for dental treatment is responsible for all fees incurred at that visit**
- **I further understand that I am responsible for ALL fees, regardless of insurance coverage.**

Patient's printed name:_____
Patient's Signature:_____
Guardian's Signature (if patient is younger than 18):_____
Today's Date:_____

Waverley Dental Care
David Salibian D.M.D.
333 Trapelo Rd.
Belmont, MA 02478

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 4/16/03, 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 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 with your healthcare or with payment for your healthcare, but only if you agree that we may 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 person 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 such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that 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 or 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 $0.35 for each page, $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. 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 your 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 you 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 complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

_____

Waverley Dental Care

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

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

_____

Printed Name

_____

Signature

_____

Date

For Office Use Only

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

- ☐ Individual did not sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

_____

_____

_____