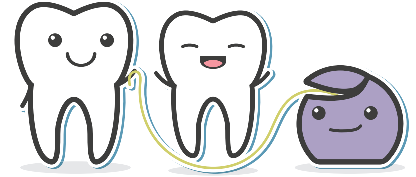
HASSEY | DO DUY
DENTAL ASSOCIATES

100 Milk Street, Suite 120
Methuen, MA 01844

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.



PATIENT INFORMATION

Today's Date		
Name of Minor / Child	Birth Date	Social Security Number

Nickname	Hobbies	Gender ☐Male ☐Female Age ____

Home Address	City	State	Zip Code
Mailing Address	City	State	Zip Code

Cell Phone	School Name	School Phone

Name of Person Financially Responsible for this Account	Relationship to Patient	Cell Phone

Whom may we thank for referring you?

DENTAL INSURANCE INFORMATION

Father / Guardian's Name	Birth Date	Social Security Number

Address (If different from the patient)	City	State	Zip Code

Cell Phone	Work Phone	Do you have dental insurance for the minor / child? ☐ Yes ☐ No

Email Address	Employer

Insurance Company	Group Number	Policy Number

Insurance Company Address	City	State	Zip Code

Mother / Guardian's Name	Birth Date	Social Security Number

Address (If different from the patient)	City	State	Zip Code

Cell Phone	Work Phone	Do you have dental insurance for the minor / child? ☐ Yes ☐ No

Email Address	Employer

Insurance Company	Group Number	Policy Number

Insurance Company Address	City	State	Zip Code

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No	Child Medical Assistance I.D. Number

DENTAL HISTORY

Reason for today's visit	Date of Last Dental Exam
Previous Dentist / Location	Date of Last Dental X-rays

Has child complained about dental problems? ☐ Yes ☐ No
Does child brush teeth daily? ☐ Yes ☐ No
Does child use floss daily? ☐ Yes ☐ No
Is fluoride taken in any form? ☐ Yes ☐ No

Any injuries to mouth, teeth, head? ☐ Yes ☐ No
Any unhappy dental experiences? ☐ Yes ☐ No
Any mouth habits - thumb-sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ☐ Yes ☐ No

OVER PLEASE

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MEDICAL HISTORY

Minor / Child's Physician's Name	Date of Last Visit

City / State	Physician's Phone Number

Is Minor / Child under care of physician now? ☐ Yes ☐ No If yes, please explain? ____________________

Receiving any medication or drugs? ☐ Yes ☐ No If yes, please explain? ____________________

Ever been hospitalized? ☐ Yes ☐ No If yes, please explain? ____________________

Ever had surgery? ☐ Yes ☐ No If yes, please explain? ____________________

Is there excessive bleeding when cut? ☐ Yes ☐ No If yes, please explain? ____________________

Does the minor / child have any allergies? ☐ Yes ☐ No If yes, please explain? ____________________

Has minor / child had any history of or difficulty with any of the following? If yes, please indicate.

☐ AIDS/HIV Positive	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rhuematic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other ____________

EMERGENCY CONTACT

Name	Relationship	Phone Number

Name	Relationship	Phone Number

AUTHORIZATIONS

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the doctor if my minor child ever has a change in health.

Minor / Child Consent

I am the parent, guardian, or personal representative of ______________________________ (Please Print Name of Minor / Child) and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to preform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with ______________________________ (Name of Insurance Company(ies) and assign directly to Dr. ______________________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______________________________	______________________________
Signature of Patient, Parent, Guardian or Personal Representative	Please print name of Patient, Parent, Guardian or Personal Representative
______________________________	______________________________
Relationship to Patient	Date

UPDATES (To be filled in at future appointments)

Has there been any changes in the patients health since their last dental appointment? ☐ Yes ☐ No
If yes, please explain? ____________________

Is the patient taking any new medications? ☐ Yes ☐ No If yes, please explain? ____________________

Parent / Guardian Signature ____________________ Date ____________________

Doctors Signature ____________________ Date ____________________

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Communication is important to us as a part of your complete dental care.
Please take a moment of your time to review our policies.

FIRST APPOINTMENT

Your first appointment will consist of a full mouth series of x-rays and a full oral exam. If you have any recent x-rays taken from a previous dentist, please try to obtain a copy and bring them with you on your first appointment.

MEDICAL HISTORY

We will ask that you review your medical history at each recall visit with your hygienist. Many changes occur in your health that we need to be aware of.

RECALL APPOINTMENTS

You are encouraged to schedule your recall appointment in advance. We will send a reminder postcard 2 weeks in advance of these visits. A reminder will also be sent if you choose not to schedule your appointment in advance.

CANCELED/FAILED APPOINTMENT

Notifying us 48 hours in advance of your appointment will help us to avoid scheduling problems.

PAYMENTS

Payment is expected at the time of each visit. We will advise you of your treatment needs and estimated expense. Should your treatment be extensive, we can arrange for a plan to pay. We accept Master Card, Visa, Discover, and American Express. We also offer a payment plan called CareCredit that allows treatment to start today and spreads payments over time. These arrangements will be discussed individually.

Your account must remain in good standing prior to your next visit.

INSURANCE

Our front desk staff will provide the courtesy of submitting your dental claims, including a reasonable follow-up of unpaid claims. You will be expected to provide a percentage of your fee at each visit. Our new computer system allows us to continually update your specific insurance policy. You will see that our billing system will become more accurate to your "estimated portion due." Until specific information is collected, your payment will be based on the insurance standard of: 100% Hygiene visits, 80% Restorative visits, 50% Major restorative visits.

Please note that generally insurance benefits for posterior white fillings is minimal. Please check with your provider for benefits.

Patient Signature ______________________ Date ______________________

HIPAA PRIVACY FORM 2

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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

____
Please Print 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)

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Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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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 ______________, 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.______ 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 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: ____

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