Patient Information

Last Name:	First Name:
Preferred Name:	Date of Birth:
Sex: Male ☐ Female ☐	Employer:
Where did you hear about us?	

Insurance Information

	Primary Dental Insurance	**Secondary Dental Insurance**
Insurance Company		
Policy Number		
Subscriber's Name		
Subscriber's Relationship to Patient		
Subscriber's Date of Birth		
Subscriber's Employer		
Subscriber's Address		

Dental Information

What brings you to our office today?	
Date of last dental exam: / /	Have you had orthodontic treatment? Yes ☐ No ☐
Date of last dental cleaning: / /	Have you had periodontal treatment? Yes ☐ No ☐
Date of last dental x-rays: / /	Do you grind your teeth? Yes ☐ No ☐
Do your gums bleed when brushing or flossing? Yes ☐ No ☐	Any other dental concerns?

My signature indicates that the above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the treating dentist or dental practice. **I understand that I am financially responsible for any balance. I understand that, if I don't have dental insurance, I must pay for all services at the time of treatment.** I also authorize Associates in Comprehensive Dental Care or insurance company to release any information required to process my claims.

Patient/Guardian Signature ______________________________ Date ________________

Golden 10 Mapleville PLLC

Assoc In Comp Dental Care | 10 Mapleville Depot • St. Albans, VT 05478 (802)524-5169

Medical & Dental History Form

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________ ____________ ____ ____________
Last First MI Preferred Name

Title: ________ **Gender:** ◯ Male ◯ Female ◯ Other **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

In case of emergency please list name and phone number of who should be notified?

____

____

Your Primary Care Physician's name, address, phone number and date of last medical exam?

____

____

Preferred Pharmacy, Location, and Phone number:

____

____

Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? ____________

Please list any medications you are currently taking:

____

____

____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphonates? ◯ Yes ◯ No

Do you have, or have you had, any of the following?

- [ ] AIDS/HIV Positive
- [ ] Alzheimer's Disease
- [ ] Anaphylaxis
- [ ] Anemia
- [ ] Angina/Chest Pain
- [ ] Anxiety
- [ ] Arthritis/Gout
- [ ] Artificial Heart Valve
- [ ] Artificial Joint
- [ ] Asthma
- [ ] Blood Disease
- [ ] Breathing Problems
- [ ] Bruise Easily
- [ ] Cancer
- [ ] Chemotherapy
- [ ] Cold Sores
- [ ] Congential Heart Disorder
- [ ] Depression
- [ ] Diabetes
- [ ] Difficulty Swallowing
- [ ] Drug Addiction
- [ ] Easily Winded
- [ ] Emphysema
- [ ] Epilepsy or Seizures
- [ ] Excessive Bleeding
- [ ] Excessive Thirst
- [ ] Fainting Spells/Dizziness
- [ ] Frequent Cough
- [ ] Frequent Diarrhea
- [ ] Frequent Headaches
- [ ] Frequent Snoring
- [ ] Glaucoma
- [ ] Hay Fever
- [ ] Headaches/Migraines
- [ ] Heart Attack/Failure
- [ ] Heart Pacemaker
- [ ] Heart Disease
- [ ] Hemophilia
- [ ] Hepatitis A
- [ ] Hepatitis B or C
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Hives or Allergic Rash
- [ ] Hypoglycemia
- [ ] Irregular Heartbeat
- [ ] Kidney Problems
- [ ] Leukemia
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Lung Disease
- [ ] Lyme Disease
- [ ] Osteoporosis
- [ ] Pain in Jaw Joints
- [ ] Parathyroid Disease
- [ ] Psychiatric Care
- [ ] Radiation Treatment
- [ ] Recent Weight Loss
- [ ] Renal Dialysis
- [ ] Shingles
- [ ] Sickle Cell Disease
- [ ] Sinus Problems
- [ ] Sleep Apnea
- [ ] Stomach/Intestinal Disease
- [ ] Stroke
- [ ] Swelling of Limbs
- [ ] Thyroid Disease
- [ ] Tonsilitis
- [ ] Tuberculosis
- [ ] Tumors or Growths
- [ ] Ulcers
- [ ] Jaundice

Do you have any other health issues other than those listed above?

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____

____

Are you Allergic to any of the following?

- [ ] Penicillin
- [ ] Amoxicillin
- [ ] Codeine
- [ ] Acrylic
- [ ] Metal
- [ ] Latex
- [ ] Sulfa Drugs
- [ ] Local Anesthetics

Do you have any allergies other than those listed above? If yes, please specify.

____

____

Authorization

- [ ] ***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 authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account. I understand that I am financially responsible for any outstanding balance for services 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 on my behalf or on behalf of my dependents (if any).**

Please type Name of Person Completing form and Relationship to Patient:
(Please sign in the box below if completing paper forms)

____

____

____

Response Date: __________

Insurance Information

As a courtesy to our patients, we are happy to file insurance claims on your behalf. We will make every reasonable effort to collect proposed covered amounts from your insurance company to reimburse our patients for out-of-pocket costs. Deductibles and non-covered amounts for all services are due on date of service unless prior arrangements have been made. It is the responsibility of the patient to know and keep track of their dental plan coverage, deductibles and maximums and waiting periods. We will perform a thorough, comprehensive exam to determine your needs. We are dedicated to helping you understand your current level of dental health, your treatment choices, and the consequences of those choices. Once you have that information, you may decide to proceed with the option that is best for you. Because our obligation is only to you, once you have made your treatment choices, there will be no compromise in rendering it. Regardless of the type of plan you participate in, we still assist you with filling your claims. As your dental healthcare advocates, we will provide any documentation required to your dental plan so that you may receive the re-imbursement you are entitled to. We are, however, powerless to influence plan benefits negotiated between your employer and the insurance company. Please be advised that there are some insurances that we are not in-network with, which may cause coverage to vary. The patient is ultimately responsible for all charges incurred that are not covered under plan benefits. Any unpaid claims will become the sole responsibility of the patient. I also give permission to Associates in Comprehensive Dentistry to bill my dental insurance as a courtesy to me. My signature below indicates that I have read and understood the above dental insurance information.

Patient Name & Signature: ___________________________________ Date: _______________

NOTICE OF PRIVACY PRACTICES

Associates in Comprehensive Dental Care
Kristina Leska, DDS
Selma Mohammedi, DMD

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 7/18/2016 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/ or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities including billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a call, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official 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 the protected health information of an inmate or patient. **Secretary of HHS.** We will disclose your health information to the Secretary of the U.S.Department of Health and Human Services when required to investigate or determine compliance with HIPAA. **Worker's Compensation**. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order. **Health Oversight Activities.** We may disclose your PHI an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for license and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.
Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.
Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Other Uses and Disclosures of PHI

Your authorization is require, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this notice for an explanation of our fee structure.
If you are denied for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.
Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.
Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.
Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.
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 amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.
Right to Notification of a Breach. You will receive notifications of breaches of your unsecured Protected health information as required by law. **Electronic Notice**. You may receive a paper of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices of have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or if 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.

Our Privacy Official: Kristina Leska, DDS Telephone: 802-524-5169 Fax: 802-527-7184
Address: 10 Mapleville Depot St. Albans, VT 05478

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

On occasion, parents, guardians, spouses and other relatives are involved in the care of patient(s). Please list any other person(s) who may inquire about/discuss the patient's protected health information, for example: treatment and insurance.

Name: ____ Relationship: ______________________

Name: ____ Relationship: ______________________

Associates in Comprehensive Dental Care has a Notice of Privacy Practices, which sets forth the ways in which my personal health information may be used or disclosed by Associates in Comprehensive Dental Care, and outlines my rights with respect to such information. I hereby acknowledge that I chose to read this notice, or declined, knowing I may see them at any given time.

Patient's name (please print) ____

Signature of Patient/Guardian ____ Date:___________

CANCELLATION POLICY FOR ALL PATIENTS PLEASE READ AND SIGN

Each hour in the dental chair is expensive to maintain and staff. We are happy to reschedule your appointment if you call us at least a day in advance. If we don't hear from you at least 24 hours before the appointment, that missed hour is your responsibility. There will be a $50 fee for missed appointments. My signature below indicates that I have read and understood the Cancellation Policies.

Signature of Patient or Responsible Party____

10 Mapleville Depot, St. Albans, VT 05478
802-524-5169
contactus@acdcdds.com

Consent to Receive Electronic Messages

By signing below, I authorize Associates in Comprehensive Dental Care through its vendor *Dentrix HUB* to contact me via SMS text message regarding appointment reminders, as well as to confirm appointments.

I understand any applicable message and data rates are my responsibility. I know that I am under no obligation to authorize *Dentrix HUB* to send me text messages as part of this program.

I may opt out of receiving these communications at any time by calling Associates in Comprehensive Dental Care at the number listed above.

Name (print) ____

Signature ____