Central New England
DENTAL ASSOCIATES

PATIENT INFORMATION FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ M ☐ F	Today's Date:
Birth Date:	Marital status:	Email:	
Address:			
Primary Phone:	Secondary Phone:		
I prefer to be contacted by email phone text			
In case of emergency please contact:			Phone:
Who may we thank for referring you?			

Who will be responsible for your account?			Relation:
Driver's License#:	Birth Date:	Phone:	
Address:			
Dental Insurance?	Company:	ID# or SS#	

DENTAL INFORMATION		
Reason for today's appointment		
When was your last dental exam?	Bleeding gums?	Sensitive teeth?
Food caught between teeth?	If you could change anything in your Smile what would that be?	

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain:
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain:
Have you ever had a serious head or neck injury? Yes No If yes, please explain:
Do you use tobacco? Yes No if yes, how much per day?
Do you use controlled substances? Yes No
Do you need to pre-medicate? Yes No If yes, please explain:

Women only	Any possibility of pregnancy?
	Expected delivery date?
	Nursing?
	Taking birth control?

MEDICATION HISTORY

Are you now taking or have taken:

Nerve pills	☐ Yes ☐ No	Pain Killers (including Aspirin) ☐ Yes ☐ No	Stimulants ..... ☐ Yes ☐ No
Diet pills	☐ Yes ☐ No	Muscle Relaxers ..... ☐ Yes ☐ No	Insulin ..... ☐ Yes ☐ No
Blood thinners	☐ Yes ☐ No	Tranquilizers..... ☐ Yes ☐ No	Antidepressants ☐ Yes ☐ No
Any bone density medications (Boniva, Fossamax, Actonel) ..... ☐ Yes ☐ No			

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Are you allergic to or had a reaction to:

Penicillin ..... ☐ Yes ☐ No	Valium or other tranquilizers ..... ☐ Yes ☐ No	Soy ..... ☐ Yes ☐ No
Latex ..... ☐ Yes ☐ No	Aspirin ..... ☐ Yes ☐ No	Codeine or other narcotics ..... ☐ Yes ☐ No
Sulfa ..... ☐ Yes ☐ No	Local Anesthetics ..... ☐ Yes ☐ No	Sulfites ..... ☐ Yes ☐ No

HEALTH HISTORY

AIDS/HIV Positive .....☐Yes ☐No	Excessive Bleeding.....☐Yes ☐No	Leukemia ..... ☐Yes ☐No
Alzheimer's Disease.....☐Yes ☐No	Kidney Problems.....☐Yes ☐No	Stroke ..... ☐Yes ☐No
Anaphylaxis.....☐Yes ☐No	Stomach/Intestinal Disease..... ☐Yes ☐No	Liver Disease ..... ☐Yes ☐No
Anemia.....☐Yes ☐No	Irregular Heartbeat.....☐Yes ☐No	Hives or Rash ..... ☐Yes ☐No
Angina.....☐Yes ☐No	Spina Bifida.....☐Yes ☐No	Heart Pace Maker ..... ☐Yes ☐No
Arthritis/Gout.....☐Yes ☐No	Shingles.....☐Yes ☐No	Sickle Cell Disease ..... ☐Yes ☐No
Artificial Heart Valve.....☐Yes ☐No	Epilepsy or Seizures.....☐Yes ☐ No	Hepatitis A ..... ☐Yes ☐No
Artificial Joint.....☐Yes ☐No	Convulsion.....☐Yes ☐No	Hepatitis C ..... ☐Yes ☐No
Asthma.....☐Yes ☐No	Frequent Diarrhea.....☐Yes ☐No	Hepatitis B.....☐Yes ☐No
Chemotherapy.....☐Yes ☐No	Radiation Treatments.....☐Yes ☐No	Congenital Heart Disorder ..... ☐Yes ☐No
Blood Disease.....☐Yes ☐No	High Blood Pressure.....☐Yes ☐No	Heart Attack.....☐Yes ☐No
Blood Transfusion.....☐Yes ☐No	Any Joint replacement .....☐Yes ☐No	Hemophilia.....☐Yes ☐No
Breathing Problem.....☐Yes ☐No	Emphysema.....☐Yes ☐No	Renal Dialysis.....☐Yes ☐No
Bruise Easily.....☐Yes ☐No	Frequent Cough.....☐Yes ☐No	Sinus Trouble.....☐Yes ☐No
Cancer.....☐Yes ☐No	Tuberculosis.....☐Yes ☐No	Tonsillitis.....☐Yes ☐No
Chest Pains.....☐Yes ☐No	Ulcers.....☐Yes ☐No	Heart Murmur.....☐Yes ☐No
Cortisone Medicine .....☐Yes ☐No	Fainting Spells/Dizziness.....☐Yes ☐No	Rheumatic Fever.....☐Yes ☐No
Diabetes.....☐Yes ☐No	Hypoglycemia.....☐Yes ☐No	Parathyroid Disease.....☐Yes ☐No
Drug Addiction.....☐Yes ☐No	Excessive Thirst.....☐Yes ☐No	Scarlet Fever.....☐Yes ☐No
Frequent Headaches.....☐Yes ☐No	Thyroid Disease.....☐Yes ☐No	Lung Disease.....☐Yes ☐No
Glaucoma.....☐Yes ☐No	Mitral Valve Prolapse.....☐Yes ☐No	Venereal Disease.....☐Yes ☐No
Hay Fever.....☐Yes ☐No	Pain in Jaw Joints.....☐Yes ☐No	Psychiatric Care.....☐Yes ☐No
Heart Attack/Failure.....☐Yes ☐No	Tumors or Growths.....☐Yes ☐No	Rheumatism.....☐Yes ☐No
Heart Trouble/Disease.....☐Yes ☐No	Yellow Jaundice.....☐Yes ☐No	Recent Weight Loss.....☐Yes ☐No
Low Blood Pressure.....☐Yes ☐No	Herpes.....☐Yes ☐No	Other .....☐Yes ☐No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Reviewed by Dr.	Date

Central N.E. Dental Associates

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 9/15/05 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: Abhayjit S. Bedi, D.M.D, M.S.

Telephone: 508-832-5731 Fax: 508-832-0289

E-mail: ∅

Address: 176 Auburn Street
Auburn, MA 01501

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(This Form is educational only, does not constitute legal advice, and covers only federal, not state, law in effect or proposed as of March 27, 2002. Subsequent law changes may require Form revision.)

CENTRAL NEW ENGLAND DENTAL ASSOCIATES
176 Auburn Street
Auburn, MA 01501

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.
Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.
It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.
Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be Provided

I understand that during my course of treatment that the following care may be provided:
Examinations____ Preventative Services____ Restorations____
Crowns____ Bridges____ Other____ Patient Initials_____

2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Patient Initials_____

3. Changes in Treatment Plan

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 root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. Patient Initials____

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. Patient Initials____

Patient Signature_____ Date_____

Missed Appointment Policy

We do our best to keep the cost of your dental treatment as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us with 48 hours notice another patient who could have been seen was not.

As a result we find it necessary to charge a 50.00 fee for missed appointments without 48 hour notice.

Initials _____