D A D I A L A
FAMILY DENTISTRY

Dadiala Family Dentistry
1345 Lakeview Ave
Dracut, MA 01826

T: (978) 957-5511

info@dadialafamilydentistry.com

PATIENT REGISTRATION

Office Use: Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: _____

How did you hear about us?: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2 - Employment Information

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Pharmacy: _____

Employer ID: _____

Carrier ID: _____

Section 3 - Emergency Contact Information

Name: _____

Relationship to Patient: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Address: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

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 _____

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HEALTH HISTORY

PATIENT NAME _____ Birth Date _____

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: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments:

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 _____

Patient Name: _____ Date: _____

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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.

DADIALA FAMILY DENTISTRY

Dadiala Family Dentistry is required by law to maintain the privacy of your protected health information (PHI) and to provide individuals with notice of its legal duties and privacy practices currently in effect with respect to PHI. This Notice describes how we may use and disclose your PHI for treatment, payment, and for health care operations as well as for other purposes that are permitted or required by law. 45 CFR § 164.520.

Dadiala Family Dentistry reserves the right to change the terms of this Notice and make the new notice provisions effective for all the PHI we maintain. If Dadiala Family Dentistry makes a material change to this Notice, we will post the changes promptly on our website at www. DadialaFamilyDentistry.com and a paper copy of this Notice is available upon request.

Effective Date

This Notice of Privacy Practices became effective on June 01, 2021 and was amended on May 01, 2023.

Types of Uses and Disclosures of your PHI

"Treatment" – We will use and disclose your PHI to provide, coordinate or manage your dental health care and any related services. We will also disclose PHI to other providers who may be treating you such as a specialist.

"Payment" – We will use your PHI to obtain payment for the dental health care services provided. For example, we may provide information to a health insurance company or business associate to obtain payment for the treatment provided for you.

"Healthcare Operations" –We will use your PHI to support the management of our dental office. For example, we may use information about you to conduct quality performance reviews regarding our services or the performance of our staff. Additionally, we may obtain services from business associates such as training programs, legal services and insurance.

HITECH Amendments

HITECH Act Breach Notification Requirements: The HITECH Act requires us to notify each individual whose unsecured PHI has been, or is reasonably believed to have been accessed, acquired or disclosed due to a breach. The HITECH Act imposes a similar requirement on Business Associates. "Unsecured PHI" refers to PHI that is not secured through the use of technologies or

methodologies that render the PHI unusable, unreadable, or indecipherable to unauthorized individuals.

Restriction of Disclosure: The HITECH Acts restricts us from refusing an individual's request not to use or disclose the individual's PHI in instances where the patient's services were paid out of pocket to prevent the information from flowing to the health plan since no claim is being made against the third party payer.

Access to Electronic Health Records (EHRs): The HITECH Act expands the right of records access. Individuals have the right to access their EHR in an electronic format and to direct us to send the e-record directly to a third party. We may only charge for the labor costs to transfer this information.

Expansion of Accounting of Disclosures: The HITECH Act removed the accounting of disclosures exception of PHI to carry out treatment, payment and healthcare operations. All such disclosures must be accounted for if the disclosure is made through an EHR. We also will provide the individual with a list and contact information for all relevant business associates to obtain an accounting of disclosures of PHI.

Prohibition on Sale of PHI: The HITECH Act prohibits covered entities and business associates from receiving indirect or direct remuneration in exchange for PHI without obtaining an authorization from the individual unless such an exchange meets one of the exceptions listed by the government.

Dadiala Family Dentistry Responsibilities

Certain Uses or Disclosures: We will use and disclose your PHI when required to by federal, state or local law.

Appointment Reminders: We may contact you to provide appointment reminders via telephone or post cards. We may contact you to provide information about treatment alternatives or other health related benefits and services that may be of interest to you.

Revocation: Other uses and disclosures will be made only with your written authorization and you may revoke such authorization.

Public Health & Safety: We will use and disclose your PHI to public health authorities permitted to collect or receive information for the purpose of controlling disease, injury or disability.

Individual Rights

Request Restriction of Disclosures: You have the right to request restrictions on certain uses and disclosures of PHI and under HIPAA, Dadiala Family Dentistry is not required to agree to the restriction unless as clarified by defined by the HITECH Act.

Right to Receive Confidential Communications: You have the right to receive confidential communications. Please specify your preference of communication in writing to us such as your home telephone, work telephone, mobile telephone, and / or email. We may provide relevant portions of your PHI to a family member, relative, close friend or any other person you identify as being involved in your dental care or payment.

Right to PHI: You have the right to inspect and copy the PHI that we maintain about you in our designated record set for as long as we maintain the information. We may charge a fee for the costs

of copying, mailing or other supplies used in fulfilling your request. Please contact the Privacy Officer to inspect your record or receive a copy.

Right to Amend: You have the right to request that we amend your health information if you feel it is incomplete or inaccurate. You must make the request in writing to our Privacy Officer stating the reasoning that supports your request. We may deny the request if the information was not created by our office or if the person who created it is no longer available to make this amendment.

Right to Accounting: You have the right to receive an accounting of disclosures of your health information as required by law. Please submit a written request to our Privacy Officer.

Right to Paper Copy: You have a right to obtain a paper copy of the Notice of Privacy Practices.

Request Information or File a Complaint

If you have questions, would like additional information or want to report a problem regarding the handling of your PHI, you may contact the Privacy Officer at:

Dadiala Family Dentistry
1345 Lakeview Ave.
Dracut, MA 01826
978-957-5511
978-9576419 Fax

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our Practice. You may also file a complaint with the Secretary of Health and Human Services at:

U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Room 515 F HHH Building
Washington, D.C. 20201
www.hhs.gov/ocr

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Financial Policy

Your Insurance may be quite challenging and our goal is to assist you in maximizing your benefits. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments. By signing this policy, you acknowledge the following.

OUR COURTESY SERVICE TO YOU INCLUDES:

1. Filling your claim within 24hrs of your visit and requesting payment of benefits to our office.
2. Electronically filing your insurance for short turnaround.
3. Researching your dental insurance plan to advise you of your benefits available to you.
4. Re-filling your insurance a second time within 60 days.
5. Following the Dadiala Family Dentistry guidelines for coding procedures and filling insurance.

OUR EXPECTATIONS OF YOU AS THE OWNER OF THE POLICY:

1. Payment of fees not covered by your insurance plan at the time the services are delivered.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Realizing that dental insurance policies restrict payment for some services, use restricted fee Schedules (called Usual & Customary Rates) and exclude some procedures based on the premium paid for the insurance not our fees or recommended treatment.
4. Taking responsibility for payment if the insurance company does not pay our office within 75 days or if they pay less than what was expected, deny claim, or pay you directly.
5. Keeping our office informed of any changes in your insurance coverage or employment.

TREATMENT ESTIMATES AND INSURANCES:

Based on information we receive from you, your insurance carrier, or benefit information we may have on file for your employer, we will give you treatment estimate on what you can anticipate your co-payment to be.

PLEASE UNDERSTAND THAT THESE ARE ONLY ESTIMATES:

Dadiala Family Dentistry does not presume to act as a representative of your insurance carrier. We will not know the benefit amounts available until actual payment from your insurance carrier is received.

IF YOU DO NOT HAVE INSUREANCE:

Please not the **ALL PAYMENTS ARE DUE IN FULL AT THE TIME OF THE SERVICE.**
We accept cash, checks and most major credit cards.
There will be a $25.00 fee charged to the patient for any returned checks.

MISSED APPOINTMENT POLICY WEEKDAY AND SATURDAY:

Unless at least 24 hour notice is given when cancelling weekday or Saturday appointments, there will be a fee of $50 charged to your appointment.

I HAVE READ, UNDERSTAND, AND AGREE TO THE TERMS OF THIS FINANCIAL POLICY.

_____ _____

Patient Full Name **Date**

I certify that all the blanks in this form were filled in prior to signature and that I explained this form to the patient/parent/guardian before requesting signature and all and any questions from the patient have been reviewed and discussed.

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Notice of Privacy Practices Informed Consent

I _____ understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (E. G. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice,

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

_____ _____

Patient Signature/Parent Guardian Date