WOBURN DENTAL ASSOCIATES

PLEASE *READ* AND *COMPLETE* ALL FORMS *PRIOR* TO YOUR APPOINTMENT SO THAT WE MAY BEGIN YOUR TREATMENT *ON TIME.*

THANK YOU

WOBURN DENTAL ASSOCIATES
INSURANCE and FINANCIAL POLICY

At ***Woburn Dental Associates***, we strive to provide the best care to our patients. Some have dental insurance that may offset the cost of the treatment we recommend. Some do not have this benefit and the cost of dental care is totally an out of pocket expense. Here are some important things about our financial policy that you should know.

PLEASE INITIAL

- ____Your dental policy involves a relationship between you, the patient, and your insurance provider. Claims are filed as a ***courtesy*** by Woburn Dental Associates and we do not accept responsibility for approval, denial or payment of any benefits. All charges for treatment rendered are the ultimate responsibility of the patient, regardless of insurance coverage.

- ___Woburn Dental Associates is contracted as a network provider for Delta Dental of MA Premier Plans, Blue Cross Blue Shield of MA Dental Blue Plans We will accept other insurance plans only if those plans allow you to seek a dentist outside their network.

- ____We are happy to submit "pre-treatment authorizations" which help us to determine what treatment is covered and gives us estimates of possible insurance benefits. Please keep in mind that these are ***ONLY*** estimates and that neither your insurance company nor Woburn Dental Associates can guarantee payment. Benefits can only be confirmed when claims are processed and paid.

- ____Woburn Dental handles hundreds of policies and claims. Although we strive to stay abreast of our patients' used and remaining benefits, treatment that has been rendered *outside* of this office and paid by your insurance may not be considered when calculating costs. Therefore, it may be impossible to determine your exact out of pocket expenses due to these variables. We can only use the most up to date information available to us at the time. You, the patient, assume the final responsibility for obtaining information about your policy and its' benefits.

- ____If insurance benefits cannot be confirmed, payment in full is expected at the time of treatment. When insurance benefits are confirmed, we will collect the appropriate deductible and co-payment amounts on the day services are rendered. Again, benefits ***cannot be guaranteed*** until claims are processed, so some claims may result in an additional expense not quoted at the time of treatment.

- ____Payment *in full* for your portion is required at the time of service unless prior arrangements have been made. We accept MasterCard, Visa, American Express, Discover and cash. Personal checks are accepted *only* for existing patients with established payment history. There will be a $50 charge for all returned checks after which remaining balances must be paid thereafter with credit card or cash only. We also work with CareCredit, who offers short term, no interest loans for qualified applicants. This option may help you complete necessary treatment with a payment plan to fit your specific needs. Please note, the agreement is between you, the patient, and CareCredit. All payments and fees are paid directly to CareCredit by the patient.

- ____Appointment time is reserved for you and we strongly encourage all of our patients to keep scheduled appointments. If you must change your appointment, we do require at least 24 hours notice. There will be a $50 cancellation fee for those cancelled without 24 hour notice. For those who cancel or fail more than 3 consecutive appointments, there will be $150 fee to reschedule, which is non-refundable if the appointment is failed or cancelled without 24 hour notice.

I agree with the above conditions.

Print Name_____ Date_____

Patient/Guardian Signature_____

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

First Name_____ **Last Name**_____ **Middle Initial**_____

Preferred Name_____

Street Address_____ **City**_____ **State, Zip**_____

Home Phone_____ **Work Phone**_____ **Ext**_____ **Cell Phone**_____

Birth Date_____ **Social Security#**_____ **e-mail**_____

Responsible Party (if someone other than patient)_____

Employer Name & Address_____

Person Guaranteeing Payment on Account_____

Payment is expected when services are rendered

Names, Addresses & telephone numbers of Persons to contact in Case of Emergency:

1st_____

2nd_____

How did you become familiar with our office?_____

Will you be using Dental Insurance? Yes___ No___

	PRIMARY INSURER	**SECONDARY INSURER**
Name of Insured Person		
Insured Person SS#		
Insured Person ID#		
Insured Person Birth Date		
Employer Name		
Insurance Company Name		
Group/Plan/Policy#		

Is the Patient a Full Time Student, 19 years or older? Yes___ No___

Name and Address of School_____

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT, REGARDLESS OF INSURANCE COVERAGE.

_____ _____

SIGNED PATIENT, PARENT OR LEGAL GUARDIAN DATE

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO INSURANCE CLAIMS & ALL GROUP INSURANCE BENEFITS PAYABLE DIRECTLY TO WOBURN DENTAL ASSOCIATES.

_____ _____

SIGNED PATIENT, PARENT OR LEGAL GUARDIAN DATE

NOTICE OF PRIVACY PRACTICES

(DENTAL)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, 20___ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Consent

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: _____ Date: _____

Patient, parent or legal guardian

If signed by patient representative, state relationship to patient _____

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.

_____
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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DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below and read and sign the bottom of the form

___1. WORK TO BE DONE
I understand that I am having the following work done: Fillings_____Bridges____Crowns_____Extractions____Root Canals_____Other_____Initials_____

___2. DRUGS AND MEDICATIONS
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). 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. Initials_____

___4. REMOVAL OF TEETH
Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the dentist to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or in rare occasions may be permenant; or fractured jaw.

_____ _____
Patient Signature Date

_____ _____
Dentist Signature Date

_____ _____
Witness Signature Date