Welcome To Our Practice

Thank you for scheduling an appointment with **Nashoba Family Dentists**.
It is our goal to prepare you for your initial visit with us to ensure that your visit is a pleasant one.

What Will You Need To Bring With You?

- Insurance Card or Proof of Insurance
- Completed and Signed Medical History/HIPAA/General Consent Form
- If under the age of 18, a parent or legal guardian must be present
- Any previous x-rays (within last year, or 5 years for panoramic or full-mouth xrays)
- Payment: We accept cash, checks, major credit/debit cards and Care Credit

What Is Our Billing Policy?

- We are a "Fee For Service" Office, which means that payment is always expected at time of service. If for some reason you are unable to make full payment on date of service please speak with our staff at the front desk. We will be happy to estimate all future charges for you.
- Insurance – We will bill your insurance company directly, expecting payment. If, for any reason, your insurance company does not pay for your visit, the ultimate responsibility for payment is yours. Your deductible and co-pay are expected at time of service when applicable. We are happy to assist you with questions regarding your dental insurance.
- Billing – We will mail you a statement. If several statements are sent with no response, your account will be forwarded directly to our collection agency.

IF A PATIENT NEEDS TO BE PRE-MEDICATED FOR DENTAL WORK, PLEASE CALL THE OFFICE PRIOR TO THE APPOINTMENT AND INFORM US.

We hope you enjoy your first visit with us! We look forward to meeting you and your family. If you have any questions, please do not hesitate to call. Our patients are our number one priority!!

Sincerely,

Nashoba Family Dentists

Contact Information

Telephone: (978) 486-8261
Fax: (978) 486-4437
Address: 256 Great Road, Suite 5 – Littleton, MA 01460
Email: info@nashobafamilydentists.com

NASHOBA
FAMILY DENTISTS

Date_______________

Patient Information

Name ____ Birthdate ___________ SS# __________ ☐ Male ☐ Female

Address _____________________________________ City ________________ State ________ Zip Code ________

Home Phone _______________ Cell Phone _______________ Email ____

Check Appropriate Box ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employer _________________________ Occupation ______________________ Work Phone _________________

Emergency Contact Person ____________________________ Phone ____________________________________

Student Status ____ School ________________________________

Person responsible for account _____________________________ Referred by ____________________________

Dental Insurance

Primary Insurance

Name of Insured ______________________________

Date of Birth ________________________________

Relationship to Patient _________________________

Insurance Company Name _______________________

Employer ____________________________________

ID/SS # __________________ Group # ____________

Secondary Insurance

Name of Insured ______________________________

Date of Birth ________________________________

Relationship to Patient _________________________

Insurance Company Name _______________________

Employer ____________________________________

ID/SS # __________________ Group # ____________

Dental History

Previous dentist & location ______________________________________ Date of last exam __________________

How often do you floss? ______________________________ How often do you brush? __________________________

Have you had any problems associated with previous dental treatment? _____________________________________

Please check all that apply:

☐ Bad Breath
☐ Bleeding Gums
☐ Frequent Headaches
☐ Jaw, Head, or Neck Injuries
☐ Sensitivity to Hot
☐ Dry Mouth
☐ Loose Teeth or Broken Fillings
☐ Orthodontic Treatment
☐ Finger Nail Biting
☐ Grinding Teeth
☐ Sensitivity to Cold
☐ Dentures/Partials
☐ Sensitivity to Sweets or Biting
☐ Blisters on Lips or Mouth
☐ Periodontal Treatment
☐ Lip or Cheek Biting
☐ Tooth Pain

Health History

Physician's Name ____ Date of Last Visit ________________________

Check the Appropriate Answer:

☐ Yes ☐ No Are you currently under medical treatment? If yes, explain ____________________________________

☐ Yes ☐ No Are you taking any medications now? If yes, explain ____

☐ Yes ☐ No Have you had any serious illness or operations? If yes, explain ________________________________

☐ Yes ☐ No Do you smoke or drink alcohol? If yes, how often ____

☐ Yes ☐ No Do you need to pre-medicate for dental procedures? If yes, specify condition _____________________

☐ Yes ☐ No Do you have any allergies?

☐ Local Anesthetics ☐ Penicillin ☐ Latex ☐ Sulfa Drugs
☐ Aspirin ☐ Iodine ☐ Metals/Jewelry ☐ Sedatives
☐ Other, please specify: ____

Women Only: Are you Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Please check all that apply:

☐ High Blood Pressure
☐ Rheumatic Fever
☐ Sinus Trouble
☐ Swollen Ankles
☐ Fainting/Seizures
☐ Asthma
☐ Low Blood Pressure
☐ Epilepsy/Convulsions
☐ Leukemia
☐ Diabetes
☐ Kidney Disease
☐ Eating Disorder
☐ Angina
☐ Heart Murmur
☐ Other ______________________
☐ Thyroid Problem
☐ Frequently Tired
☐ Severe Headache/Migraines
☐ Anemia
☐ Emphysema
☐ Cancer
☐ Arthritis
☐ Joint Replacement/Implant
☐ AIDS or HIV Infection
☐ Hepatitis/Jaundice
☐ STD ___________
☐ Osteoporosis
☐ Heart Attack
☐ Mitral Valve Prolapse
☐ Chest Pains
☐ Hay Fever Allergies
☐ Sleep Apnea/Snoring
☐ Stroke
☐ Tuberculosis
☐ Radiation Therapy
☐ Glaucoma
☐ Recent Weight Loss
☐ Liver Disease
☐ Respiratory Problems
☐ Stomach Trouble/Ulcer
☐ Reflux/Persistent heartburn
☐ Heart Disease
☐ Cardiac Pacemaker

Please initial if nothing is checked ______

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me or services rendered. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges not covered by my insurance company.

Patient or Guardian Signature ____ Date ______________________

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 1/1/03, 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 dentist, 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 you 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 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 a $15 administrative fee, per patient, 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 a 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.

Telephone: (978) 486-8261
Fax: (978) 486-4437
Address: 256 Great Road, Suite 5 – Littleton, MA 01460
Email: info@nashobafamilydentists.com

Nashoba Family Dentists

Acknowledgement of Receipt of Notice of Privacy Practices

****You may refuse to sign this acknowledgement****

I, ____, have received a copy of this office's
(please PRINT name)
Notice of Privacy Practices.

Signature: ____Date: __________________

Release of Information

I, ____, give permission for my dental
(please PRINT name)
and/or account information to be discussed with the following person(s):

Spouse: ____

Parent: ____

Other: ____

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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) ____

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 Basic and Major Treatment. 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

__________________________________ ____________________________

Parent / Guardian Signature for children under 18 Date