VILLAGE DENTAL OF NEW ENGLAND

Leonard E. Di Paolo, DDS

Better Teeth, Better Health, Better Life!

Date: ____________________

Name: ____ S.S.# ______-______-_______

Address: ____

City / State/ Zip: ____

Home Phone: __________________________________ Work Phone: __________________________________

Cell Phone: _________________________ E-Mail Address: ____

Date of Birth: _______________________ Gender ☐M ☐F Marital Status: ☐ S ☐M ☐D ☐ W

Employer Name: ____

Employer Address – Street and Number ____

City/State/Zip ____

Occupation: ____Pharmacy of choice:_________________________

If full-time student, name of school attending: ____

In case of Emergency, whom should we notify? ____

Phone #: ____________________________________ Relationship: ____

Who will be responsible for this account? ____

How did you learn of our office? ____

Primary Dental Insurance: ____

Insured Person: ________________________ Group#: ________________________ I.D.#: ____________________

Insured Person Date of Birth: ____ S.S.# ______-______-_______

Insured Person Employed By: ____

Secondary Insurance: ____

Insured Person: ________________________ Group#: ________________________ I.D.#: ____________________

Insured Person Date of Birth: ____ S.S.# ______-______-_______

Insured Person Employed By: ____

Authorization to release information ____

Authorization to assign benefits to doctor: ____

Signature of Responsible Party/Guardian____**Date**________________________

VILLAGE DENTAL OF NEW ENGLAND, PLLC

BETTER TEETH, BETTER HEALTH, BETTER LIFE

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 ______________________________

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?

Condition		Condition		Condition		Condition	
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 ______________________________

Comments: ______________________________

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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 ____________________

VILLAGE DENTAL OF NEW ENGLAND
INSURANCE and FINANCIAL POLICY

Better Teeth, Better Health, Better Life!

At ***Village Dental of New England***, 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 Village Dental 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 coverage.
- ___ Village Dental is contracted as a network provider for **Northeast Delta Dental Premier Plans** and **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 of their network. Be aware that in-network and out-of-network benefits may differ. Please understand that Dentists who choose to contract as a network provider agree to *discount* their fees with little or no ability to negotiate those fee allowances. For that reason, it is not practical to join ***all*** dental networks.
- ___ We will be happy to submit "pre-treatment estimates" 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 not Village Dental can guarantee payment. Benefits can only be confirmed when claims are processed and paid.
- ___ Village Dental handles hundreds of insurance 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 expense 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 co-payment amounts on the day services are rendered. Again, benefits ***cannot be guaranteed*** until claims are processed, so some claims may result in 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, Discover and cash. Personal checks are accepted only for existing patients with an established payment history. There will be a $50 charge for all returned checks after which, remaining balances must be paid by credit card or cash only. We also work with **CareCredit™** and **Lending Club™**, who offer short term, no or low 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™** or **Lending Club™**. All payments and fees are paid directly to **CareCredit™** or **Lending Club™** 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 48 hours notice. There will be a $50 cancellation fee for those cancelled without 48 hours notice. For those who cancel or fail 3 consecutive appointments, there will be a $150 fee to reschedule, which will be credited toward the cost of treatment, but is non-refundable if the appointment is failed or cancelled without 48 hours notice.

I agree with the above conditions.

Print Name____ Date__________________________

Patient/Guardian Signature____

Diagnostic X-Ray and Photo Consent

I,______________________________ hereby authorize Dr. DiPaolo and his team to take photographs and x-rays of my face, jaw, mouth and teeth.
I understand that photographs and x-rays will be used as a record of my care and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations and professional publications and promotional purposes.
I further understand that if photographs are used in any publication or as part of a demonstration, my name and other identifying information WILL BE KEPT CONFIDENTIAL.
I hereby release and discharge Dr. Di Paolo and all persons functioning under his permission or authority from legal or equitable claims including, but not limited to, blurring of images, alterations, distortion or use in composite form, libel, invasion of privacy and claims based upon the production or in the process of publishing the materials.

Signature:___________________________________ Date:____________
Name: (print)____
Guardian: (If under 18)____

LEONARD E. DI PAOLO, D.D.S.

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

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe in this notice while it is in effect. This notice takes effect April, 14 2003, 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 applicable law permits the changes. We reserve the right to make the changes in our privacy practice 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 health care operations. For example:

Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditations, certification, licensing or credentialing activities. We may disclose your health information to another health care provide or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: 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 uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use of disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with the opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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. We may use or disclose information about you to notify or assist in notifying a person involves in your care, of your location and general condition.

Appointment Reminders: We may use of disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters)

Disaster Relief: We may use or disclose your medical information as authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law;
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury.
- To report adult abuse, neglect, or domestic violence;
- To health oversight agencies;
- In response to court and administrative orders and other lawful processes;

- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- To coroners, medical examiners, and funeral directors;
- To an organ procurement organizations;
- To avert a serious threat to health or safety;
- In connection with certain research activities;
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- To correctional institutions regarding inmates; and
- As authorized by state worker's compensation laws.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limiter expectations. 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 request access by sending us a letter to the address at the end of this notice. 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 may- but are not required to- 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 more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which our business associates or we disclosed your health information over the last 6 years (but not before April 14, 2003). That list5 will not include disclosures for treatment, payment, health care operations, as authorized by your and for certain other activities. 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. Contact us using the information listed at the end of the notice for more information about fees.

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). Any agreement we may make to a request for additional restrictions must be in writing, signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communications: 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. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right that we amend you health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices of have questions or concerns, please contact us using the information listed at the end of this notice.

If you believe that:

- We may have violated your privacy rights,
- We made a decision about access to your health information incorrectly,
- Our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- We should communicate with you by alternative means or at alternative locations.

You may contact us using the information listed below. 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.

Provider Contact Office Leonard E. Di Paolo, DDS
Telephone (603) 382-1585
Address 89 Main St.
Plaistow, NH 03865

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

By signing below, you understand and accept the terms of our privacy practice.

Signature of Responsible Party/Guardian____________________________________Date____________________