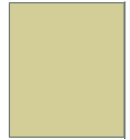
SALEM FAMILY DENTAL CARE, PC

10 FEDERAL STREET SUITE 16 SALEM MA 01970



Welcome to Salem Family Dental Care!

Patient Information:

First Name: ______________________ Last Name: ________________________

Sex: ____Male _____ Female Birth Date: _____________ Age: ____

Home Phone: ________________ Cell/Work Phone: ______________

Address: ___________________________ City: ___________________ State: ____ Zip Code: ___________

Email: _______________________________ Social Security Number____________________________

Appointment Reminders: ____ Yes, Please Email Me _____ Yes, Please Text Me

Responsible Party: _____ Self _____ Parent/Guardian

First Name: ____________________ Last Name: ______________________ Birth Date: ______________

Address: ___________________________ City: ___________________ State: ____ Zip Code: ___________

Whom can we thank for your referral?:____

Emergency Contact:____________________ Phone Number____________________________

Primary Insurance Policy:

Primary Insurance: _________________________________ Policy ID # ______________________________

Policy Holder's Name: ________________________ Policy Holder's Birth Date:___________________

Patient's Relationship to Policy Holder: ___________________________

Secondary Insurance Policy:

Secondary Insurance: _________________________________ Policy ID # ___________________________

Policy Holder's Name: ________________________

Policy Holder's Birth Date: ______________________

Patient's Relationship to Policy Holder: ________________

Medical History

Patient Name: ________________________________ Birth Date: ______________________

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:

____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ___ Yes ___ No If yes, please explain:

____

Are you allergic to any of the following? ___ Aspirin ___ Penicillin ___ Codeine ___ Acrylic ___ Metal ___ Latex ___ Local Anesthetics ___ Sulfa Drugs ___ Other:____

Are you on a special diet? ___ Yes ___ No

Pregnant? ___ Yes ___ No

Nursing? ___ Yes ___ No

Taking Oral Contraceptives? ___ Yes ___ No

Do you use tobacco? ___ Yes ___ No

Do you use controlled substances? ___ Yes ___ No

Do you have/ had, any of the following? (Please Circle)

∗ AIDS/HIV Positive ∗ Diabetes ∗ Herpes ∗ Rheumatic Fever ∗ Alzheimer's Disease ∗ Drug Addiction ∗ High Blood Pressure ∗ Rheumatism ∗ Anaphylaxis ∗ Easily winded ∗ High Cholesterol ∗ Scarlet Fever ∗ Anemia ∗ Emphysema ∗ Hives/Rash ∗ Shingles ∗ Angina ∗ Epilepsy/Seizures ∗ Hypoglycemia ∗ Sickle Cell Disease ∗ Arthritis/Gout ∗ Excessive Bleeding ∗ Kidney Problem ∗ Sinus Trouble ∗ Artificial Heart Valve ∗ Fainting Spells/Dizziness ∗ Leukemia ∗ Spina Bifida ∗ Artificial Join ∗ Frequent Coughs ∗ Liver Disease ∗ Stroke ∗ Asthma ∗ Frequent Diarrhea ∗ Low

Blood Pressure * Swelling of Limbs * Blood Disease * Frequent Headaches * Lung Disease * Thyroid Disease * Blood Transfusion * Glaucoma * Mitral Valve Prolapse * Tonsillitis * Breathing Problems * Hay Fever * Osteoporosis * Tuberculosis * Cancer/Chemotherapy * Heart Attack/Failure * Pain in Jaw Joints * Tumor/Growth * Chest Pain * Heart Murmur * Parathyroid * Ulcers * Cold Sore/Fever Blister * Heart Pacemaker * Psychiatric Care * Venereal Disease * Congenital Heart Disorder * Heart Trouble/Disease * Radiation * Vision Problems * Convulsion * Hemophilia * Recent Weight Loss * Yellow Jaundice * Cortisone Medicine * Hepatitis A, B, or C * Renal Dialysis * Other __________

Additional Comments/Illness not listed above:
____

Do your gums bleed while brushing or flossing? ____Yes ____No

Are your teeth sensitive to hot or cold liquids/food? ____Yes ____No

Are your teeth sensitive to sweet or sour liquids/food? ____Yes ____No

Have you had any neck or head injuries? ____Yes ____No

Do you have frequent headaches? ____Yes ____No

Do you clench or grind your teeth? ____Yes ____No

Any difficulties with extractions in the past? ____Yes ____No

Prolonged bleeding? ____Yes ____No

Do you bite your lips or cheeks frequently? ____Yes ____No

Have you experienced any of the following in your jaw (Please check if yes):

____Clicking

____Pain (joint, ear, side of face)

____Difficulty in opening or closing

____Difficulty in chewing

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 history. Patient/Responsible

Party Signature: ______________________________________ Date: ___________________

SALEM FAMILY DENTAL CARE, PC

10 FEDERAL STREET SUITE 16 SALEM MA 01970

Informed Consent for Dental Treatment and Procedures

1. You; the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consent 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.

X-rays: *Proposed treatment: taking of intraoral and extraoral radiographs. Benefits of treatment: taking x-rays enables us to view dental cavities, abnormalities, development and eruption of teeth. They are necessary for proper diagnosis and evaluation purposes. Alternative treatment: none; limited visual examination. Consequences of not performing: missed diagnosis. Common risk: Radiation exposure to soft and hard tissue.* ______Initial

Cleaning: *Proposed treatment: involves thorough cleaning of teeth to help heal inflamed or infected gum tissue. It involves removal of soft plaque build-up and harder calculus deposits above and below the gum line. Benefit of treatment: healthy oral environment; also reduction/elimination of bleeding, odor, and periodontal disease. Alternative treatment: referrals for periodontal surgery according to the severity of condition. Consequences for not performing: discontinued or interrupted treatment could result into further inflammation and infection of gum tissues; lead to more tooth decay, and deterioration of surrounding bone structure which could lead to tooth loss. Common risk: bleeding, soreness, swelling, infection of tissue, hot and cold sensitivity, stiff or sore jaw joint.* ______Initial

2. **Drugs and Medication**

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

3. **Change of 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 dentist to make any/all changes and additions as necessary. ______Initial

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

Patient/Responsible Party Signature: ______________________________ Date: ____________________

Financial Agreement

1. **Payments**: Payment is due on day of service. Payment options are cash, debit card, checks (established patients only) or credit card (VISA, MasterCard, or Discover). For financing larger treatments, we also offer Care Credit. ______(Initial)

2. **Dental Insurance**: Insurance is a contract between you and your insurance. There is no direct relationship between Salem Family Dental Care, PC and your insurance company. Benefits are determined by the plan selected by you and/or your employer and we are not a party to this contract. The terms of your contract, methods of reimbursement, and determination of your benefits are defined by your insurance company and not Salem Family Dental Care, PC. We will file your dental insurance claims as a courtesy to you. We do not guarantee payments and are not responsible for providing you with the plan limitations, exclusions, and provisions determined by your insurance company. You agree to pay your portion of the charges, or not covered (denied) by your insurance. ______(Initial)

3. **Deposits**: To book an appointment for major services that require one or more hours, 50% of the total cost of the proposed procedures must be collected. The remaining 50% is due on day of service. ______(Initial)

4. **Cancellation/Broken Appointment**: 48 hour notice of cancellation is required for all major procedures (ie. root canal, dentures, and implants). 24 hour notice of cancellation is required for all other procedures (ie. cleaning, filling, follow up). Patients with 3 missed appointments will be asked to transfer their records to another dentist. ______(Initial)

5. **Finance Charge**: A finance charge of $5.00 will be added to your account for any balance that remains unpaid after 30 days after receipt of notice. This charge will be assessed monthly, until the remaining balance is paid in full. ______(Initial)

6. **Monthly Statement**: If you have a balance on your account, we will send you a monthly statement. It will show the previous balance, any new charges made to the account, finance charges (if applicable), and any payment or credit applied to your account during the month. Professional fees are the responsibility of the parent or guardian authorizing treatment. We cannot send statements to other persons. ______(Initial)

7. **Past Due Accounts**: If your account is past due, we will take necessary steps to collect this debt. We will refer your account to a **collection agency** after 3 attempts to collect this debt. If no payment arrangements have been made by then, we will refer the account and you agree to pay the collections costs which are incurred. ______(Initial)

8. **Effective Date**: Once you sign this agreement, you agree to all terms and conditions herein and the agreement will be in full force and effect. This agreement is between your treating dentist; Dong W. Kim or Daniel Jun, and the patient/parent/debtor named on this form. Continued In this agreement, the words “you”, “your”, and “yours” means the patient/debtor. The word “account”, means the account that has been established in the patient’s name to

which charges are made and payments are credited. The word “we”, “us” and “ours” refers to your treating dentist; Dong W. Kim or Daniel Jun at Salem Family Dental Care, PC.

By executing this agreement, you agree to the terms of the financial agreement and agree to pay for all services that are received.

____________________________ ____________________________

Patient’s Name (Print) Patient’s Name (signed)

____________________________ ____________________________

Responsible Party (Print) Responsible Party (signed)

____

Date

NOTICE OF PRIVACY PRACTICES

Protecting Your
Confidential Health Information
is Important to Us

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.

Our Promise

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPPA-Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize the protect the privacy of electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting healthcare operations, and as otherwise described in this notice.

How Your HEALTH INFORMATION May be Used to Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with care. This may include administrative and clinical procedures designed to optimize scheduling and coordination of care. In addition, we may share your health information with pharmacies or other healthcare personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate’s written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICE

Federal law generally permits us to make certain uses or disclosure of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required by Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers’ Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers’ compensation laws.

Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental Uses and Disclosures

We may use or disclosure your health information in a manner which is incidental to the uses and disclosures described in this notice.

Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert a Serious Threat to Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

Protecting Your Confidential Health Information is Important to Us

To the U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research

We may use or disclose your health information for research, subject to conditions, "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection with Your Death or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information

We are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

You have the following rights related to your health information.

Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or healthcare operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, unless (a) you request that we not disclose your PHI to a health insurance company, Medicare or Medicaid for payment or healthcare operations purposes; (b) you, or someone on your behalf, has paid us in full for the healthcare item or service to which the PHI pertains; and (c) we are not required by law to disclose to the insurer, Medicare, or Medicaid the PHI that is the subject or your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we do not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a health care item or service for which you have paid us out-of-pocket in full.

Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with you request in writing and describe the information to be changed and your reasons for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

Receive Notice of a Security Breach

You have the right to receive notification of a breach of your unsecured health information.

Changes to the Notice

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all our patients receive a copy of the revised Notice.

Complaints

You have the right to express complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complains in writing by submitting your complaint to our Privacy Officer.

Patient Acknowledgement

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this form.

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

Patient Name: ______________________ **DOB:** ______________

Patient Signature: ______________________ **Date:** ______________

Parent/Guardian Name: ______________________ *(if applicable)*

Parent/Guardian Signature: ______________________ **Date:** ______________