Dear Patient . . .

The information you provide on these forms is confidential and will not be released to anyone without prior written consent.

The information you provide will assist us in a number of ways:

- ♦ Enable us to document and update your medical history
- ♦ To assess your present dental state of health
- ♦ To evaluate your current home care efforts
- ♦ To recommend a personal dental treatment plan of action
- ♦ To make us aware of YOUR dental health needs

DIRECTIONS TO OUR OFFICE:

From Spaulding Turnpike (North or South):

- Take Exit 8E and follow that to the first set of traffic lights
- At set of lights, turn left on Arch Street and follow to Stop Sign
- At Stop sign, turn right onto Washington Street; drive to first set of traffic lights
- At lights, turn left onto Chestnut Street; immediately on the right of the road you will see a Municipal parking lot; turn right into lot
- When you turn into lot, there will be a five story brick building on your left side; we are located on the ground floor; metered parking is available

Please read the following and answer as completely as possible.

……

Visit our website at www.belknapdental.com for more information about our practice.

Account Number _____ Date _____

THE INFORMATION YOU PROVIDE ON THIS FORM IS CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR PRIOR WRITTEN CONSENT.

PATIENT REGISTRATION

Patient Name_____ Birth Date _____

Spouse _____

Address _____

City _____ State _____ Zip _____

Email Address: _____

Complete only if mailing address is not the same as above:

Mailing Address _____

City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____

Drivers license # _____ Social Security # _____

Male ❑ Female ❑ Married ❑ Single ❑

Employer's Name _____ Business Phone # _____

If patient is a student, age 18 or older:

Name of school:_____ State:_____

PERSON RESPONSIBLE FOR THIS ACCOUNT

IF SAME AS ABOVE, PLEASE DO NOT COMPLETE

Guarantor Name _____ Birth Date _____

Relationship _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____ Social Security # _____

Employer's Name _____ Business Phone # _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____ Phone # _____

PLEASE...

Who may we thank for referring you to our office? _____

Account Number _____ Date _____

Patient Name _____

DENTAL INSURANCE COVERAGE

Policy Holder's Name _____ Policy Holder's DOB _____

Policy Holder's SS # _____ Policy Holder's ID# _____

Employer Name _____

Employer Address _____

Dental Insurance Company _____ Phone # _____

Insurance Address _____

Policy # _____ Group # _____

Person(s) covered by this insurance: _____

If secondary applies:

Policy Holder's Name _____ Policy Holder's DOB _____

Policy Holder's SS # _____ Policy Holder's ID# _____

Employer Name _____

Employer Address _____

Dental Insurance Company _____ Phone # _____

Insurance Address _____

Policy # _____ Group # _____

Person(s) covered by this insurance: _____

As a courtesy and convenience to you, our office will submit charges for dental services to your insurance carrier. However, the patient is **primarily responsible** for the financial charges. In other words, the service provided by any dentist or hygienist amounts to an agreement between the patient and the office. The insurance relationship constitutes an agreement between the carrier and the patient.

Please remember, however, that insurance benefits are determined by the type of plan chosen by your employer. We urge you to read your policy so you are fully aware of any limitations of the benefits provided. Of course, we will do whatever we can to see that you receive maximum benefits within the structure of your particular group dental plan.

If there is any question regarding your account, please call. Many times a phone call will prevent a misunderstanding.

Please read our insurance brochure for complete dental insurance information.

Patient Insurance Consent

I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This form also authorizes Belknap Dental Associates to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist(s) to release treatment records / x-rays or any information deemed pertinent to my insurance carrier as necessary and / or requested.

Patient/ Parent or Guardian Signature: _____ Date: _____

Account Number _____ Date _____

Patient Name _____

MEDICAL HISTORY

	Yes	No
Are you having pain or discomfort at this time?	❑	❑
Have you been a patient in the hospital during the past two years?	❑	❑
Have you been under the care of a medical doctor during the past two years?	❑	❑
Are you currently being treated by a physician? If so, why _____		
Physician's Name _____		
Phone No. _____		
Have you taken any medication or drugs during the past two years?	❑	❑
Are you now taking any medication, drugs or pills? If yes, please list:	❑	❑
_____ What for: _____		
_____ What for: _____		

Are you aware of being allergic to or have you ever reacted adversely to any of the following medication or substance? Please circle if yes:

Penicillin	Codeine	Latex
Erythromycin	Aspirin	Local Anesthetic (Novocaine)
Sulfa	Nickel	Any other, please list: _____

	Yes	No
When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?	❑	❑
Do your ankles swell during the day?	❑	❑
Do you use more than two pillows to sleep?	❑	❑
Have you lost or gained more than 10 pounds in the past year?	❑	❑
Do you ever wake up from sleep and feel short of breath?	❑	❑
Are you on a special diet?	❑	❑

FOR WOMEN ONLY:

Are you pregnant? If yes, what month? _____	❑	❑
Are you nursing?	❑	❑
Are you taking birth control pills?	❑	❑

Do you have or have you been treated for: (Please check Yes or No)

	Yes	No
Any Heart	❑	❑
Heart failure	❑	❑
Stroke	❑	❑
Heart Disease or Attack	❑	❑
Angina Pectoris	❑	❑
Congenital Heart Disease	❑	❑
Heart Valve Defect	❑	❑
Heart Murmur	❑	❑
High Blood Pressure	❑	❑
Low Blood Pressure	❑	❑
Arteriosclerosis	❑	❑
Mitral Valve Prolapse	❑	❑
Artificial Heart Valve	❑	❑
Heart Pacemaker	❑	❑
Heart Surgery /By-Pass	❑	❑
Bacterial Endocarditis	❑	❑
Rheumatic Fever	❑	❑
Artificial Joints (hip, knee etc)	❑	❑
Tuberculosis	❑	❑
Emphysema	❑	❑
Chronic Cough	❑	❑
Do you Smoke	❑	❑
Asthma	❑	❑

	Yes	No
Bronchitis	❑	❑
Hay Fever	❑	❑
Allergies or Hives	❑	❑
Sinus Trouble	❑	❑
Lung / Breathing Problems	❑	❑
Radiation Therapy	❑	❑
Chemotherapy	❑	❑
Cancer/Tumor/Other Growths	❑	❑
Hepatitis - A, B, or C (please circle)	❑	❑
Venereal Disease	❑	❑
A.I.D.S	❑	❑
H.I.V. Positive	❑	❑
Sexually Transmitted Diseases	❑	❑
Other Infectious Diseases	❑	❑
Blood Transfusion	❑	❑
Hemophilia	❑	❑
Anemia	❑	❑
Sickle Cell Disease	❑	❑
Bruise Easily	❑	❑
Difficulty Healing	❑	❑
Any Bleeding Disorders	❑	❑
Adrenal / Pituitary Problems	❑	❑

Continued Next Page

Account Number _____ Date _____

Patient Name _____

	Yes	No		Yes	No
Arthritis	❑	❑	**Liver Disease**	❑	❑
Cortisone Medicine	❑	❑	Yellow Jaundice	❑	❑
Ulcers/Stomach Problems	❑	❑	**Epilepsy or Seizures**	❑	❑
Diabetes	❑	❑	Fainting or Dizzy Spells	❑	❑
Thyroid Problems	❑	❑	**Alcoholism**	❑	❑
Glaucoma	❑	❑	Drug Addiction	❑	❑
Cosmetic Surgery	❑	❑	**Nervousness / Mental Disorder**	❑	❑
Cold Sores/Fever Blisters	❑	❑	Psychiatric Treatment	❑	❑
Kidney Trouble	❑	❑	**Developmentally Disabled**	❑	❑

Do you have or have you had any disease, condition, or problem not listed above? ❑ ❑
If yes, please list:

_____ _____

Do you need to take antibiotic pre-medications prior to dental appointments? ❑ ❑
Name of antibiotic: _____

DENTAL HISTORY

	Yes	No
What is the reason for this appointment?_____		
Name of your previous dentist:		
_____		
Reason for leaving your previous dentist: _____		
Do you have any dental records from your previous dentist?	❑	❑
When was your last visit to the dentist? _____ Last cleaning? _____		
What was done at that time? _____		
Are you satisfied with the appearance of your teeth?	❑	❑
If not, please explain: _____		
How would you describe you dental health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor		
Have you noticed a change in the position of any of your teeth?	❑	❑
Do your gums bleed? If so, when? _____		
Are any of your teeth loose?	❑	❑
Do you have pain or soreness in teeth or gums?	❑	❑
Are your teeth sensitive to sweets?	❑	❑
Do you notice "popping" or "clicking" or pain in your jaw?	❑	❑
Do you clench or grind your teeth?	❑	❑
Have you had any teeth removed?	❑	❑
Have you had orthodontic treatment?	❑	❑
Have you had periodontal treatment?	❑	❑
Are you wearing any removable dentures?	❑	❑
List any dental conditions of which you are aware that have not been mentioned:		
_____		

Patient Insurance Consent

- I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
- I authorize the Dentist (s) or designated staff treating me to perform diagnostic procedures deemed appropriate to make a thorough diagnosis of my oral health. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures including administering medications as prescribed by the Dentist (s) and mutually agreed upon by me.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 30 days from the date of treatment will be assessed a late charge per month and if payment is not received within 90 days, I agree to pay any additional charges associated with collections.

Signature of Patient or
Parent/Guardian if Patient is a minor _____ Date _____

Signature of Doctor _____ Date _____

Protecting Your
Confidential Health Information is Important to Us
Updated with new guidelines August 2013

Belknap Dental Associates

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect August 1, 2013, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

Our Privacy Official: ***Kelly Levy***
Telephone: ***(603) 742-4735*** *Fax:* ***(603) 742-9911***
Address: ***40 Chestnut Street, Suite 2, Dover, NH 03820***
E-mail: ***Kelly@belknapdental.com***

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

for updated guidelines effective August 2013

Name: _____ **Date of Birth:**_____

TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURES

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

EMAILING X-RAYS

In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker service.

I understand that x-rays might need to be emailed to other specialists and dentists. I give my permission for this service.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.