Belknap Dental Associates
New Patient Paperwork

Date_____

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

For BDA only:
Patient Acct # _____

PATIENT REGISTRATION

Patient's Legal Name_____ Preferred Name: _____ Gender: _____

Birthdate _____ _____ _____ Social Security # _____ _____ _____ Email Address: _____

Drivers license # _____ Home Phone #_____ Cell Phone #_____

Address _____

City _____ State _____ Zip _____

Appointments can be confirmed by the following: (multiples can be checked)

❑ Text to cell ❑ Call to home ❑ Email

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

Mailing Address _____ Married ❑ Single ❑

City _____ State _____ Zip _____

Employer's Name _____ Business Phone # _____

PERSON RESPONSIBLE FOR THIS ACCOUNT (IF DIFFERENT THAN PATIENT)

Legal Name _____ Birthdate _____ _____ _____ Social Security # _____ _____ _____

Relationship _____ Employer's Name _____ Work Phone #_____

Address _____

City _____ State _____ Zip _____

Email Address: _____ Home Phone # _____ Cell Phone # _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____ Relation _____ Phone # _____

TEXTING CONSENT

Please check the box below to give your consent and opt in to receive text messages from Belknap Dental Associates. By opting in, you agree to receive appointment reminders, important updates, and feedback requests via text message. Standard messaging rates may apply. *You can opt out at any time by replying 'STOP' to any message.

☐ **I consent and opt in to receive text messages from Belknap Dental Associates.**

Patient/ Parent or Guardian Signature: _____ Date: _____

Please note that messaging is not a secure form of communication, and we recommend discussing any sensitive or personal information during your office visits.

Patient Name (please print)_____ Date _____

PRIMARY DENTAL INSURANCE COVERAGE

Policy Holder's Name _____ Policy Holder's DOB ____ _____ _____ Relation: _____

Employer Name _____

Employer Address _____

Dental Insurance Company _____ Phone # _____

Insurance Address _____

Person(s) covered by this insurance: _____

_____

Policy Holder's SS # _____

Policy Holder's ID# _____

Policy # _____

Group # _____

SECONDARY DENTAL INSURANCE COVERAGE

Policy Holder's Name _____ Policy Holder's DOB ____ _____ _____ Relation: _____

Employer Name _____

Employer Address _____

Dental Insurance Company _____ Phone # _____

Insurance Address _____

Person(s) covered by this insurance: _____

_____

Policy Holder's SS # _____

Policy Holder's ID# _____

Policy # _____

Group # _____

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. We will endeavor to ensure that you receive maximum benefits consistent with your group dental plan.

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

Patient Insurance / Payment 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.

I understand I am responsible payment of services at the time they are rendered. If the office participates with my insurance, I understand I am also responsible for any co-payment and deductible at the time service is rendered. 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.

Patient/ Parent or Guardian Signature: _____ Date: _____

EMAILING X-RAYS

To provide the best treatment for our patients, it may be necessary for us to email x-rays to other specialists or dentists. This allows other offices access to diagnostic information which may facilitate your diagnoses and treatment.
I understand that x-rays might need to be emailed to other specialists and dentists. I give my permission for this service.

Patient/ Parent or Guardian Signature: _____ Date: _____

Patient Name (please print) _____ Date _____

Medical Questionnaire	Y	N	If yes, please explain
Are you having pain or discomfort at this time?			
Have you been hospitalized or had a major operation during the past year?			
Have you been under the care of a medical doctor during the past year?			
Are you currently being treated by a physician? If so, physician's name and reason			
Have you taken or changed any medication or drugs during the past year?			
Are you now taking any medication or supplements? If yes, please list name and what it is for **Note: If 3 or more daily prescriptions, please provide a list**			
Do you take, or have you taken, Phen-Fen or Redux?			
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?			
Do you use any form of tobacco, cannabis and/or vaping? If so, how often?			
Do you have any artificial joints? (hip, knee, etc)			
Are you taking any blood thinners?			

Women: are you? (please check)

	Pregnant/trying to get pregnant		Nursing		Taking oral contraceptives

Are you allergic to any of the following? (please check if you are allergic)

	Penicillin		Codeine		Latex		Erythromycin		Food allergies:
	Aspirin		Local anesthetics		Sulfa Drugs		Sulfate		Nickel

	Y	N	
Any other allergies not listed?			
Do you use controlled substances?			

Do you have, or have you had, any of the following heart conditions?

	Y	N		Y	N
Any heart issues			Heart Pacemaker		
Angina Pectoris			Mitral Valve Prolapse		
Heart Disease or Attack			Stroke		
Heart Valve Defect			Artificial Heart Valve		
Congenital Heart Disease			Arteriosclerosis		
Heart Murmur			Bacterial Endocarditis		
Heart Surgery/By-pass			High Blood Pressure		
Heart Failure			Low Blood Pressure		

Do you have, or have you had, any of the following conditions?

	Y	N		Y	N
Arthritis			Epilepsy or Seizures		
Diabetes			Ulcers/stomach issues		
Kidney Trouble			Rheumatic Fever		
Thyroid Problems			Cold sores/Fever blisters		
Adrenal/Pituitary Problems			Difficulty Healing		
Glaucoma					

Have you been treated or have you received any of the following?

	Y	N		Y	N
Radiation Therapy			Liver Disease		
Chemotherapy			Hepatitis: (please circle)		
Cancer/Tumor/Other			A B C D E		

Do you have, or have you had, any of the following bleeding issues?

	Y	N		Y	N
Hemophilia			Sickle Cell Disease		
Anemia			Bruise Easily		
Blood Transfusion			Any Bleeding Disorders		

Do you have, or have you had, any of the following breathing issues?

	Y	N		Y	N
Lung/Breathing Issues			Chronic Cough		
Emphysema			Sinus Trouble		
Bronchitis			Asthma		
Tuberculosis			Fainting or Dizzy Spells		

Are you or have you been treated for the following?

	Y	N		Y	N
Venereal Disease			Drug Addiction		
A.I.D.S.			Alcoholism		
Sexually Transmitted diseases			Nervousness / Mental Disorder		
H.I.V. Positive			Psychiatric Treatment		
Other Infectious Diseases			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? If so, name of antibiotic

Patient Name (please print) _____ Date _____

Dental Questionnaire	**Y**	**N**	If yes, please explain
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 your 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:			

I understand that the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I (or the minor patient) may need during diagnosis and treatment with my informed consent.

Patient / Parent or Guardian Signature: _____ Date: _____

Signature of Doctor _____ Date: _____

H.I.P.A.A. CONSENT

I (or minor patient), _____, I acknowledge that I have been provided a copy of Belknap Dental Associates' Notice of Privacy Practices, which has an effective date of 9/23/2013, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practice at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of

Patient / Parent or Guardian Signature: _____ Date: _____

Protecting Your Confidential Health Information is Important to Us

Belknap Dental Associates

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

for updated guidelines effective August 2013

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. 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.

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 replaced.

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:
- **National Security.** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's 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***