BOSTON DENTAL GROUP Inc

Patient Information

Name_____ □Dr □Mr □Mrs □Miss □Ms

Last First MI

Preferred Name:_____

Address_____City_____State_____Zip_____

Home phone _____Work Phone_____Cell Phone_____

Sex □ Male □ Female Are You: □Minor □Married □Divorced □Widowed □Single □Separated

Date of Birth_____ Age _____ Social Security # _____

E-mail_____

Which one do you prefer us to use as primary point of contact: □Home □Work □Cell □Email

You or your parent's employer_____Occupation_____

Work Address_____City_____State_____Zip_____

Employer Phone#_____ ID#_____

Spouse's Name_____Spouse's Employer_____

Spouse's Social Security#_____ Legal Guardian_____

Who may we thank for referring you?_____

Contact in case of emergency_____Relationship_____Phone_____

Insurance Information (if you do not have physical insurance card, please complete below)

Dental Insurance □ Yes □ No

If yes, Policy Holder Name:_____ Policy Holder Date of Birth :_____

Member ID # (or SSN#) :_____ Group (Policy) #: _____

Ins. Co. Name/Address: _____

Insurance company phone#_____

Relationship to Patient_____

Assignment and Release

I understand that I am financially responsible for all charges whether or not paid by insurance. I, the undersigned, certify that I (or my dependant) have insurance coverage and sign directly to Dr. Kim/ Dr. You all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor(s) to release all information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature_____**Relationship**_____**Date**_____

Dental History

Name of your former Dentist_____Phone_____

Reason for today's visit_____

Date of last exam and Professional Dental Cleaning_____

Please check any of the following conditions that apply to you:

☐ Sensitivity to sweets/ to temperature ☐ Bleeding gums or have pain
☐ Clicking or popping jaw ☐ Clenching or grinding teeth

Are you allergic or sensitive to: ☐Aspirin ☐Penicillin ☐Codeine ☐Latex ☐Acrylic ☐ Sulfa Drugs ☐Metal

☐Local Anesthetics like Lidocaine.

☐Other drugs or Medicines (list)_____ ☐Food (list)_____

Medical History

Name of Physician_____Phone_____Date of last visit_____

Do you have, or have you had, any of the following:

☐ **Exposed to COVID19 (Coronavirus) or Confirmed**

☐AIDS/HIV Positive
☐Alzheimer's Disease
☐Anaphylaxis
☐Anemia
☐Angina
☐Arthritis/Gout
☐Artificial Heart Valve
☐Artificial Joint
☐Asthma
☐Blood Disease
☐Blood Transfusion
☐Breathing Problem
☐Bruise Easily
☐Cancer
☐Chemotherapy
☐Chest Pains
☐Cold Sores/Fever Blisters
☐Congenital Heart Disorder
☐Convulsions
☐Cortisone Med
☐Diabetes
☐Drug Addiction
☐Easily Winded
☐Emphysema
☐Epilepsy or Seizures
☐Excessive Bleeding
☐Excessive Thirst
☐Fainting Spells/Dizziness
☐Frequent Cough
☐Frequent Diarrhea
☐Frequent Headaches
☐Genital Herpes
☐Glaucoma
☐Hay Fever
☐Heart Attack/Failure
☐ Heart Murmur
☐Heart Pace Maker
☐Heart Trouble/Disease
☐Hemophilia
☐Hepatitis A
☐Hepatitis B or C
☐Herpes
☐High Blood Pressure
☐ High Cholesterol
☐Hives or Rash
☐Hypoglycemia
☐Irregular Heartbeat
☐Kidney Problems
☐Leukemia
☐Liver Disease
☐Low Blood Pressure
☐Lung Disease
☐Mitral Valve Prolapse
☐Osteoporosis
☐Pain in Jaw Joints
☐Parathyroid Disease
☐ Psychiatric Care
☐Radiation Treatments
☐Recent Weight Loss
☐Renal Dialysis
☐Rheumatic Fever
☐Rheumatism
☐Scarlet Fever
☐Shingles
☐Sickle Cell Disease
☐Sinus Trouble
☐Spina Bifida
☐Stomach/Internal Disease
☐Stroke
☐Swelling of Limbs
☐Thyroid Disease
☐Tonsillitis
☐Tuberculosis
☐Tumors or Growths
☐Ulcers
☐Venereal Disease
☐Yellow Jaundice

Have you ever had any serious illness not listed above? ☐Yes ☐No If yes, explain:_____

List any medication you are currently taking and the reason _____

_____

_____

(Women Only) Are you:

Pregnant/Trying to get pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

Authorization

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 (Or parent if a minor)_____**Date**_____

BOSTON DENTAL GROUP Inc

Though it is not necessary to have your consent to allow us to use or disclose your individually identifiable health information (IIHI) to others who will treat you or support in providing you quality health care services, it is important to have your consent to use or disclose your IIHI to health care plans to insure accurate and timely payments for the services rendered. The law requires that we inform you of our policy regarding the protection of your IIHI through or Privacy Notice.

ADDITIONAL DISCLOSURE AUTHORITY

I, _____, have been presented with a Privacy Notice explaining my right regarding my individually identifiable health information (IIHI). I consent to the disclosure of my IIHI for purposes of treatment, payment, release of X – Ray or other health care operations to those individuals that I have listed below:

- Name _____ Relationship _____
- Patient's Name (if under 18) _____ Relationship _____

GENERAL CONSENT AGREEMENT

This is to certify that I, undersigned, consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated and I will assume responsibility for fees associated with those procedures. Such treatment will be explained to me and will not proceed without my acceptance. I reserve the right to ask specific questions before recommended treatment commences. I understand the risk involved with treatment. No guarantee, warranty, or insurance has been given to me that the treatment will be successful or to my complete satisfaction. This consent pertains to treatment rendered upon said patient while in the physical office of BOSTON DENTAL GROUP Inc.

Signature of Patient or Legal Guardian_____Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, have received a copy of this office's Privacy Notice and Practices.

Signature_____ Date_____

Referral Information

Whom may we thank for referring you to our practice?

□ Dental specialist □ Website _____ □ Insurance Company □ Newspaper _____

□ Friend or Family Member _____ □ Other _____

THIS SECTION FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Privacy notice and Practices.
○ Obtained signature and acknowledgement of "acceptable individuals to release IIHI to" form.
○ Individual refused to sign.
○ Emergency situation prevented the patient from receiving information during initial visit.
○ Communication barrier prohibited release of IIHI and acknowledgement of agreement.

WELCOME TO BOSTON DENTAL GROUP Inc

We appreciate you choosing us to meet your dental needs. We take this responsibility seriously and our highly-qualified staff ready to accommodate you during your reserved appointment time.

Appointment Commitment

Please review the following: If unforeseen circumstances occur which make it necessary for you to change your scheduled appointment, we request that you give us at least 24 hours notice. A broken appointment, one in which a patient does not call or show up, there may be a **fee of $50.00** per missed appointment.

Insurance Policy

Importance of patient awareness regarding insurance benefits:
Boston Dental Group realizes the importance of insurance benefits. We ask patients to carefully review their policies and/or contact their insurance carriers with doubts about the terms of their coverage: benefits, frequencies, allowances, limitations, maximums and/or restrictions. Please be informed that dental insurance is a contract between patients and their insurance companies. Ideal Dental Solutions is pleased to provide the courtesy of assisting patients in filing their claims. Our dentist's focus and dedication is aimed at providing the highest quality of care, independent of the terms of your insurance coverage. Patients are encouraged to take the time to learn the extent of their coverage, and this office will make any effort to help you to make your dental needs and financial needs come into alignment. Your insurance mails a copy of an Explanation of Benefits (EOBs) to you. Please pay attention to these statements. Check your policy for a dental deductible and whether your insurance pays at a percentage or by their allowed fee schedule. We will ask you for a copy of your insurance card and benefit booklet (if available) at your first visit or at the time of dental coverage changes. **It is your responsibility to provide us with any future changes in your insurance**. If any dental services have been provided with any other provider within the existing benefit year, please advise us as well. Providing us with your Social Security number is required for accounting purposes, if you choose to do not provide the SSN the full payment is required at the time of service.

I understand and agree to the aforementioned, and I acknowledge that I am responsible for any/all remaining balance on my account not covered by insurance.

Financial Policy

In order to provide our patients with the highest quality dental care on a sound business basis, we provide estimates of fees. Patient, parent and/or guardian ("You") are responsible for the patient portion on the date of service. It is important to understand that the due amount for our service is not your insurance company's responsibility. **We will file all necessary claims to your insurance as a courtesy to you**, however it is ultimately your responsibility to resolve your insurance claim. **If the claim remains unpaid by the insurance company 45 days from the date of service, you become immediately responsible for settling the remaining balance for the service rendered. We may place any account that has been delinquent for over 45 days with a third-party collection agency. Once your account is placed in collection, you will be responsible for the collection fee incurred by us not exceeding the legal maximum (30% of original balance due). There is a $25 fee on all returned checks.**

Financial options that we provide at this time: While we strive to give you the most accurate estimated prices for any service inquiries you may have, any and all estimated prices we quote are merely for your informational purposes only. If unforeseen cost factors arise before, during or after we perform medical service, we reserve the right to adjust final price accordingly. The final price for any or all services will be determined based on the actual services rendered whether performed services were included in the estimate or not. Estimate valid only for 3 months from the date given.

Cash or check on date of service treatment. Major credit cards (American Express, Discover, MasterCard, Visa).

Extended payment plan (based on credit approval**- 4 months with CREDIT card ONLY. NO DEBIT/CHECK CARD accepted).**

It is patient's responsibility to complete treatment and follow recommended maintenance schedule. If the treatment and maintenance plans are not followed and/or appointments are missed, adverse results could affect your dental health. If the treatment plan is not followed in a timely manner, additional treatment for the involved teeth, supporting tissues, adjacent and opposing teeth, muscles or joints might become necessary. **Please be advised that this office does not offer nor perform amalgam (silver) fillings. If my insurance company chooses to reimburse only for amalgam restorations (instead of the more modern, esthetic composite resin restorations), I agree to pay any difference that may exist.**

Patient's Print Name:_____

Payment Expected at Time of Service

Patient or Guardian Signature _____ Date _____

BOSTON DENTAL GROUP Inc

PRIVACY NOTICE

The Department of Health and Human Services, Office of Civil Rights, under the Public Law 104-191, (The **Health Insurance Portability and Accountability Act of 1996)(HIPPA)**, mandates that we issue this new revised **Privacy Notice** to our patients. As part of the Privacy Standard, implemented on April 14, 2001 you are required to provide this office with a new, signed and dated, **Consent Agreement**. Every patient must receive our own Privacy Notice and execute a new Consent Agreement before this office may use you information for treatment, payment, or other health care operations (TPO). We may amend our privacy polices and practices but will always inform you of any changes that might affect your rights.

Our office will use or disclose your Protected Health Information (PHI) for purposes of treatment, payment and other healthcare purposes as required to provide you the best quality healthcare services that we office to the extent permitted by our Consent Agreement or in such specific situations, by you signed and dated authorization. Your personal health information will never be otherwise given to anyone even family members without your written consent.

In limited circumstances, the Privacy Standard permits, but does not require, covered entities to continue certain existing disclosure of health information without individual authorization for specific public responsibilities.

These permitted disclosures include: emergency circumstances; identification of the body of a deceased person, or to assist in determining the cause of death; public health needs; research, generally limited to when a waiver of authorization is independently approved by a privacy board or Institutional Review Board; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security. There are specific state laws that require the disclosure of health care information related to Hepatitis C, and AODS. Where the state laws are most stringent than HIPPA Privacy Standards, the state laws will prevail.

On some occasions, we may furnish your PHI to a third party. This could be an insurance company for the purpose of payment or another health care provider for further treatment or additional services. Although we will institute a “chain of trust” contract and monitor our business associates contract with us, we cannot absolutely guarantee that they will not use or disclose your PHI in such a way as to violate Privacy Standard.

You, the patient, have access to your health care information and may request to examine your information, may request copies of you information, and under the law, you may request amendments to you information. The physician or principal will exercise professional judgment with regard to requests for amendments and is not bound by law to make any changes to the information. If the physician or professional agrees with the request to amend the information, we are bound by law to abide the changes.

Although the law requires a signed and dated Privacy Notice, this office does not demand that you sign this agreement as a condition of receiving care. It is the law that your rights are communicated in this manner.

In complying with the Privacy Standard, we have appointed a Privacy Officer, trained our Privacy Officer and staff in the law, and implemented policies to protect your PHI. We have instituted privacy and security processes to guard and protect your **Individually Identifiable Health Information (IIHI)**. This office is taking and continues to monitor and improve steps for the protection of your information and remain in compliance with the law.