Advanced Dental Care

Patient Name: **Birth Date:** **Date Created:**

Are you under a physician's care now?	O Yes O No	If Yes:	
Have been hospitalized or had a major operation in past 5 years?	O Yes O No	If Yes:	
Have you ever had a serious head or neck injury?	O Yes O No	If Yes:	
Are you taking any medications, pills, vitamins or drugs?	O Yes O No	If Yes:	
Do you take, or have you taken, Phen-Fen or Redux?	O Yes O No	If Yes:	
Have you ever take Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	O Yes O No	If Yes:	
Are you on a special diet?	O Yes O No	If Yes:	
Do you use tobacco?	O Yes O No	If Yes:	

WOMEN: Are you...
☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following? O Yes O No (If yes, please check all that apply)
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Other: _____
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances? O Yes O No If yes:

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

AIDS/HIV Positive	O Yes O No	Cortisone Medicine	O Yes O No	Hemophilia	O Yes O No	Radiation Treatments	O Yes O No
Alzheimer's disease	O Yes O No	Diabetes	O Yes O No	Hepatitis A	O Yes O No	Recent Weight Loss	O Yes O No
Anaphylaxis	O Yes O No	Drug Addiction	O Yes O No	Hepatitis B or C	O Yes O No	Renal Dialysis	O Yes O No
Anemia	O Yes O No	Easily Winded	O Yes O No	Herpes	O Yes O No	Rheumatic Fever	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No	High Blood Pressure	O Yes O No	Rheumatism	O Yes O No
Arthritis/Gout	O Yes O No	Epilepsy or Seizures	O Yes O No	High Cholesterol	O Yes O No	Scarlet Fever	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes O No	Hives or Rash	O Yes O No	Shingles	O Yes O No
Artificial Joint	O Yes O No	Excessive Thirst	O Yes O No	Hypoglycemia	O Yes O No	Sickle Cell Disease	O Yes O No
Asthma	O Yes O No	Fainting/Dizziness	O Yes O No	Irregular Heartbeat	O Yes O No	Sinus Trouble	O Yes O No
Blood Disease	O Yes O No	Frequent Cough	O Yes O No	Kidney Problems	O Yes O No	Spina Bifida	O Yes O No
Blood Transfusion	O Yes O No	Frequent Diarrhea	O Yes O No	Leukemia	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Breathing Problem	O Yes O No	Frequent Headaches	O Yes O No	Liver Disease	O Yes O No	Stroke	O Yes O No
Bruise Easily	O Yes O No	Low Blood Pressure	O Yes O No	Swelling of Limbs	O Yes O No	Cancer	O Yes O No
Glaucoma	O Yes O No	Lung Disease	O Yes O No	Thyroid Disease	O Yes O No	Chemotherapy	O Yes O No
Hay Fever	O Yes O No	Mitral Valve Prolapse	O Yes O No	Tonsillitis	O Yes O No	Chest Pains	O Yes O No
Heart Attack/Failure	O Yes O No	Osteoporosis	O Yes O No	Tuberculosis	O Yes O No	Cold Sores/Fever Blister	O Yes O No
Heart Murmur	O Yes O No	Pain In Jaw Joints	O Yes O No	Tumors or Growths	O Yes O No	Congenital Heart Disorder	O Yes O No
Heart Pacemaker	O Yes O No	Parathyroid Disease	O Yes O No	Ulcers	O Yes O No	Convulsions	O Yes O No
Heart Trouble/Disease	O Yes O No	Psychiatric Care	O Yes O No	Venereal Disease	O Yes O No	Yellow Jaundice	O Yes O No

Have you ever had any serious illness not listed? O Yes O No If Yes:

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 medication or medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____

Advanced Dental Care

388 Cambridge Street
Burlington, MA 01803

781-272-2875

Please fill out both sides of this form and sign

Patient Information

Name: _____ Preferred Name: _____

☐ Male ☐ Female

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Child

Birth Date: _____ Social Security Number: ___-___-____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ Apartment: _____

City: _____ State: _____ Zip code: _____

Email Address: _____

Employer Name: _____ Occupation: _____

Employers Address: _____ Suite/Floor: _____

Guarantor's Information

(If same as patient write "same")

Name: _____ Preferred Name: _____

☐ Male ☐ Female

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Child

Birth Date: _____ Social Security Number: ___-___-____ License: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ Apartment: _____

City: _____ State: _____ Zip code: _____

Email Address: _____

Employer Name: _____ Occupation: _____

Employers Address: _____ Suite/Floor: _____

Insurance Information

Insurance Provider: _____ Policy Number: _____

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Patient's Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other: _____

Birth Date: _____ Social Security Number: ___-___-____ Group Number: _____

Employer Name: _____ Occupation: _____

Advanced Dental Care

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

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required 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 that are described in this Notice while it is in effect. This Notice takes effect on the date it is signed, 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. We reserve the right to make the changes in our privacy practices 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 healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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 use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also 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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

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

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in another 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 obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $10.00 for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that formal. If you prefer, we will prepare a summary or on explanation of your health Information. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other nan treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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.

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).

Alternative Communication: 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.}*** Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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 or by 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.

Contact Officer: Dr. Christopher T. McGonigle DMD.
Telephone: 781-272-2875 Fax: 781-270-9102
E-mail: drchrismcgonigle@yahoo.com
Address: 388 Cambridge Street, Burlington, MA. 01803

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in this Privacy Notice.

Print Name: _____

Signature: _____

Date: _____

Advanced Dental Care
Christopher T. McGonigle, DMD
388 Cambridge Street
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(781)272-2875

Cancelation Policy:

At Advanced Dental Care, we require a 48-Hour Cancellation Policy to reschedule a reserved appointment. It is a courtesy to all our patients and our entire team. We have this policy so that it can allow us to notify other patients who are eager to attend to their own dental needs at an earlier date or time. This policy and courtesy is extended to you as well.

As long as we receive at least 48 hours of notice to change an appointment, there will be absolutely no charge.

Should we not hear from you at least 48 hours before your reserved appointment. there will be a $75.00 fee applied to your account each time. Emergencies may be an exception.

Please be aware. repeated appointment "no-show" or cancellations with less than 48-hours' notice may result in being dismissed from the practice.

Financial Policy:

Payment in full is always due at time of service including insurance co-payments and deductibles. Prior arrangements can be made for a 3rd party payment plan including Care Credit.

As a courtesy we submit all claims to their appropriate providers. However, there is never a guarantee of payment from your insurance. While we make enormous efforts to keep updated records regarding insurance benefits. it is not always possible to ascertain exactly what insurance will pay. They provide us with an *estimate* only. Any balance remaining after insurance is the patient's responsibility.

Patients are responsible for confirming the network status of their insurance providers.

Mass Health patients: please be aware Mass Health only pays for emergency exam 2-times per calendar year. It is your responsibility to keep track of number of emergencies visits used as you are responsible for any additional non-covered charges.

Please sign on the line below stating that you are aware of our policies.
A copy of this form can be made available to you upon request.

Print name: _____

Signature: _____

Date: _____

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PATIENT FINANCIAL RESPONSIBILITY FORM

Welcome to Advanced Dental Care, we are committed to providing you with the highest quality dental care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

- The patient (patient's guardian if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service (Payment plans are available if needed)
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
    - Charges for returned checks -$25
    - Missed Appointment fee -$75

By my signature below, I acknowledge that I assume full financial responsibility for services rendered to me. If my insurance carrier denies or does not cover my claim for these services, I understand the terms of this form and accept financial responsibility with or without the use of insurance.

Patient Name: _____

Signature: _____

Date: _____