# Milford Smiles

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

## Patient Information

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

E-Mail _____ SS # _____ Birthdate _____

Check Appropriate Box: □ Minor □ Single □ Married □ Separated □ Divorced □ Widowed

If Student, Name of School/College _____ City _____ State _____

Patient's or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

## Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

E-Mail _____ Cell Phone _____

Driver's License # _____ Birthdate _____

Employer _____ Work Phone _____ SS # _____

Is this Person Currently a Patient in our Office? □ Yes □ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

□ Cash Credit Card: □ VISA □ MasterCard □ Discover □ AmEx

## Patient Dental History

Name of Previous Dentist and Location _____

| | Yes | No |
|---|---|---|
| 1. Do your gums bleed while brushing or flossing? | □ | □ |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | □ | □ |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | □ | □ |
| 4. Do you feel pain to any of your teeth? | □ | □ |
| 5. Do you have any sores or lumps in or near your mouth? | □ | □ |
| 6. Have you had any head, neck or jaw injuries? | □ | □ |
| 7. Do you have frequent headaches? | □ | □ |
| 8. Have you ever experienced any of the following problems in your jaw? | | |
| Clicking | □ | □ |
| Pain (joint, ear, side of face) | □ | □ |
| Difficulty in opening or closing | □ | □ |
| Difficulty in chewing | □ | □ |
| Do you clench or grind your teeth? | □ | □ |
| Do you bite your lips or cheeks frequently? | □ | □ |

| | Yes |
|---|---|
| 9. Have you ever had any difficult extractions in the past? | □ |
| 10. Have you ever had any prolonged bleeding following extractions? | □ |
| 11. Have you had any orthodontic treatment? | □ |
| 12. Do you wear dentures or partials? | □ |
| If yes, date of placement _____ | |
| 13. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | □ |
| 14. Do you like your smile? | □ |
| 15. Dry Mouth? | □ |

## Patient Health History

1. Is your general health good? _____
2. Has there been a change in your health within the last year? _____
3. Have you been hospitalized or had a serious illness in the last three years? _____
   If YES, why? _____
4. Are you being treated by a physician now? For What? _____
   Date of last medical exam? _____ Date of last Dental exam? _____
5. Have you had problems with prior dental treatment? _____
6. Are you in pain now?

| Have you experienced | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Chest pain (angina)? | ☐ | ☐ | Headaches? | ☐ | ☐ |
| Shortness of breath? | ☐ | ☐ | Fainting spells and/or vertigo? | ☐ | ☐ |
| Recent weight loss? | ☐ | ☐ | Blurred vision? | ☐ | ☐ |
| Persistent cough, coughing up blood? | ☐ | ☐ | Seizures? | ☐ | ☐ |
| Bleeding problems, bruising easily? | ☐ | ☐ | Excessive thirst? | ☐ | ☐ |
| Sinus problems? | ☐ | ☐ | Gastrointestinal problems? | ☐ | ☐ |
| Difficulty swallowing? | ☐ | ☐ | Jaundice? | ☐ | ☐ |
| Aphthous ulcers/canker sores? | ☐ | ☐ | | | |
| Dizziness? | ☐ | ☐ | | | |

| Do you have: | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Heart disease/heart defects? | ☐ | ☐ | Hepatitis, other liver disease? | ☐ | ☐ |
| Congenital heart problems? | ☐ | ☐ | Stomach problems, ulcers? | ☐ | ☐ |
| Mitral valve prolapses? | ☐ | ☐ | Sexually transmitted disease? | ☐ | ☐ |
| Prosthetic heart valve? | ☐ | ☐ | AIDS/HIV infection? | ☐ | ☐ |
| Rheumatic fever? | ☐ | ☐ | Herpes/cold sores? | ☐ | ☐ |
| Stroke, hardening of arteries? | ☐ | ☐ | Tumors, cancer? | ☐ | ☐ |
| Artificial joint/metal? | ☐ | ☐ | Arthritis, rheumatism? | ☐ | ☐ |
| High blood pressure? | ☐ | ☐ | Eye diseases? | ☐ | ☐ |
| low blood pressure? | ☐ | ☐ | Skin diseases? | ☐ | ☐ |
| Hypoglycemia? | ☐ | ☐ | Anemia? | ☐ | ☐ |
| Diabetes? | ☐ | ☐ | Kidney, bladder disease? | ☐ | ☐ |
| Asthma? | ☐ | ☐ | Thyroid, adrenal disease? | ☐ | ☐ |
| TB, emphysema, other lung diseases or persistent cough? | ☐ | ☐ | Eating disorders? | ☐ | ☐ |

| Do you have or have you ever had : | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Psychiatric care? | ☐ | ☐ | Blood transfusions? | ☐ | ☐ |
| Radiation treatments? | ☐ | ☐ | Surgeries? | ☐ | ☐ |
| Chemotherapy? | ☐ | ☐ | Contact lenses? | ☐ | ☐ |
| Pacemaker? | ☐ | ☐ | **Have you ever taken Fosamax, Boniva, Actonel or any medication** | | |
| Hospitalization? | ☐ | ☐ | **containing bisphosphonates?** | ☐ | ☐ |

| Are you allergic any of the following: | Yes | No | Are you taking: | Yes | No |
|---|---|---|---|---|---|
| Local Anesthetics (e.g. Novocain)? | ☐ | ☐ | Recreational drugs? | ☐ | ☐ |
| Antibiotics? | ☐ | ☐ | Controlled substances? | ☐ | ☐ |
| If so, which ones? _____ | | | Drugs, medications, over-the-counter medicines | | |
| Sulfa Drugs? | ☐ | ☐ | (including Aspirin), natural remedies? | ☐ | ☐ |
| Barbiturates? | ☐ | ☐ | Blood thinners (such as Coumadin or Warfarin)? | ☐ | ☐ |
| Sedatives? | ☐ | ☐ | Medications for opiate dependency? | ☐ | ☐ |
| Iodine? | ☐ | ☐ | Tobacco in any form? | ☐ | ☐ |
| Aspirin? | ☐ | ☐ | Alcohol? | ☐ | ☐ |
| Any Metals (e.g. nickel, mercury, etc.)? | ☐ | ☐ | **PLEASE LIST ALL MEDICATIONS** _____ | | |
| **Latex Rubber?** | ☐ | ☐ | _____ | | |
| Other? _____ | | | _____ | | |
| | | | _____ | | |
| | | | _____ | | |

| Women only: | Yes | No | All patients: | Yes | No |
|---|---|---|---|---|---|
| Are you or could you be pregnant? | ☐ | ☐ | **Do you have or have you had any other diseases or medical** | | |
| Taking birth control pills? | ☐ | ☐ | **problems NOT listed on this form? (Example, ADHD, Depression,** | | |
| Breast-feeding? | ☐ | ☐ | **Learning Disabilities)** If so, please explain: | ☐ | ☐ |
| | | | _____ | | |
| | | | _____ | | |
| | | | _____ | | |
| | | | _____ | | |

**Authorization and Release**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____

Hygienist of Doctor Comments

_____

_____

_____

Doctor Signature _____ Date _____

Hygienist Signature _____ Date _____

MILFORD SMILES

## Office Policies

1.) **GENERAL TREATMENT CONSENT**
Direct Authorization for general treatment (Preventative, Restorative, Prophylaxis and X-rays by Milford Smiles I authorize Milford Smiles for myself /parent/guardian or behalf of the Minor Patient._____ Initial

2.) **FINANCIAL AGREEMENT**
Payment is due at the time of service. As a courtesy to you, we will submit all charges to your insurance company. Insurance is designed to cover a portion of our fees only; your co-pay will be collected at each appointment. I authorize my insurance company to make direct payment to Milford Smiles.
_____Initial

3.) **CANCELLATION AND FAILURE TO KEEP APPOINTMENT**
We understand that circumstances do arise that can keep you from your scheduled appointment. We require a 48 hour notice to change/cancel any appointment, as a result of this policy the following charges may apply. General /Hygiene $60.00. Specialist 5 days notice $110.00 _____Initial

4.) **X-Rays**
Original x-rays are the property of Milford Smiles. If you request to have your x-rays duplicated, there will be a $28.00 charge. Please allow 24 hours for duplication processing, prior to pick up or mailing _____Initial

5.) **APPOINTMENT REMINDER CARDS**
**COURTESY CONFIRMATION CALLS /TEXTING/ E-MAIL**
I give Milford Smiles permission to send a reminder post card by U.S. postal service, via internet / telecommunication. _____Initial

6.) **COLLECTIONS**
Failure to pay your balance within 90 days; your account will be sent to a collection agency. There will be a $50.00 charge to process the collections account and a 20% collection cost added._____Initial

By signing below, I understand and agree to the above listed General Consent for Treatment and Office Policies, for treatment and services rendered.

**Patient/Parent/Guardian**_____**Date**_____

**Edmond Massabni, D.D.S, P.C.**
**& Associates**
**8 Asylum Street**
**Milford, MA 01757**
**(508) 473 -7632**

# 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 October 1, 2010 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 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 health information for any reason except those described in this Notice.
**To Your Family and Friends:** We must 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 disclose of your health information, we 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 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, e-mail 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 a 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 $0.50 for each page, $20 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. 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 than treatment, payment, healthcare operations, and certain other activities, of 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 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: Edmond Massabni, D.D.S, P.C.**
**Telephone: (508) 473-7632 Fax: (508) 473-7234**
**Address: 8 Asylum Street Milford, MA 01757**

**Edmond Massabni, D.D.S, P.C.**
**& Associates**
**8 Asylum Street**
**Milford, MA 01757**
**(508) 473 -7632**

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

***You May Refuse to Sign This Acknowledgement***

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

_____
**Please Print Name**

_____ _____
**Signature** **Date**

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**For Office Use Only**

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign.
_____ Communication barriers prohibited obtaining the acknowledgement.
_____ An emergency situation prevented us from obtaining acknowledgement.
_____ Other (please specify below)
_____ Comments (please specify below)

_____

_____