Newton Smile Centre

PATIENT INFORMATION

Date: _____
First name: _____ Last name: _____
Preferred name: _____ Marital status: _____ Gender: □ F □ M
Birth date: _____ Social Security#: _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____
Cell Phone: _____ Home Phone: _____
Occupation: _____ Work Phone: _____

Notify in case of emergency: _____
Phone: _____

Whom may we thank for referring you to our office?
□ Google □ Yelp □ ZOOM
□Friend: _____ □Other: _____

INSURANCE

Insurance company: _____
Patient's employer: _____
Subscriber's ID#: _____
Subscriber's name: _____
Subscriber's birth date: _____
Relationship to patient: _____

DENTAL HISTORY

Reason for today's visit: _____
Former dentist: _____
Phone: _____
Why did you leave your last dentist? _____
Date of last dental visit: _____

Would you like a whiter smile? □Yes □No
Are you satisfied with the appearance of your teeth? □ Yes □No
If no, please explain what you would like to change: _____
_____

MEDICAL HISTORY

(×) if you have or have had any of the following:

□ anemia
□ angina
□ arthritis/rheumatism
□ artificial heart valve
□ artificial joints
□ asthma
□ back problems
□ blood disease
□ blood transfusion
□ cancer/tumors
□ chemical dependency
□ chemotherapy
□ circulatory problems
□ congenital heart lesions
□ cortisone treatment
□ cough, persistent
□ cough up blood
□ diabetes
□ Emphysema
□ epilepsy/seizures
□ fainting/ dizziness
□ glaucoma
□ headaches
□ heart murmur
□ heart problems
□hemophilia/ abnormal bleeding
□ hepatitis: type_____
□ herpes
□ high blood pressure
□ HIV+/AIDS
□ jaundice
□ jaw pain
□ kidney disease
□ knee/joint replacement
□ liver disease
□ mitral valve prolapse
□ pacemaker/heart surgery
□ psychiatric care
□ radiation treatment
□ rapid weight gain or loss
□ respiratory disease
□ rheumatic/scarlet fever
□ shortness of breath
□ sinus problems
□ skin rash
□ stroke
□ swelling of feet/ankles
□ thyroid disease
□ tobacco habit
□ tonsillitis
□ tuberculosis
□ ulcer
□ venereal disease

Are you currently under physician care? □ Yes □No
Have you had any serious illnesses or operations? □ Yes □No
Do you have or have had any disease, condition or problem not listed above? □ Yes □ No
If yes, please explain: _____

List medications you are currently taking:_____
_____
Do you need antibiotic premedication prior to dental visits? □ Yes □No
If yes, please list the condition:_____

List allergies to any medication or substance:
□ aspirin □ codeine □ latex □ local anesthetic □ penicillin □ sulfa
□ other: _____

Women: are you pregnant?_____ If so, how many months?_____
Nursing?_____
Taking birth control pills?_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered every question on this form completely and accurately, to the best of my knowledge. I will inform my dentist of any change in my health and/or medication.

Patient signature: _____ Date: _____

*****Refer a patient to our practice and you will receive a $100.00 credit toward your next treatment. This offer cannot be combined with another offer. *****

FINANCIAL POLICIES

• **Full payment is due at the time services are rendered.**
We do accept assignments of your insurance benefits. However, we do require your co-payment and deductible be paid in full at the time of your appointment. The balance is your responsibility whether your insurance pays for your treatment or not. In the event that your insurance does not pay as much as we anticipate, you are responsible for the remaining bill. It is imperative that you inform us of any changes in your insurance coverage **PRIOR TO TREATMENT.**

Please be aware that not all services may be covered by insurance. The office cannot know all of the coverage limitations and rules of your plan. To avoid any miscommunication or billing disputes, please contact your insurance company before services are provided. It is important that you read and understand the provisions of your insurance.

Although we will be happy to assist you in any way we can, your insurance policy is a contract between you, your employer, and the insurance company and you are responsible for knowing your benefits. Please be aware that some, or perhaps all, of the services provided may not be covered (or may be considered at an alternate benefit). If there is a problem with your insurance company, we will try to help. **Any claims unpaid within 60 days of the date of service becomes the patient's responsibility.**

For patients without dental insurance, you are requested to pay in full at the time of service. If payment in full cannot be made at the time of service, payment arrangements must be made with the office manager in advance.

NO SHOW/ CANCELLATION POLICIES. You will receive a reminder by text message, phone and e-mail to confirm your appointment (Please notify the office if you wish to opt out of any of these options.) If you do not cancel your appointment within 2 business days or do not show up for an appointment, you will be charged a fee of $75.00, which will be due prior to your next scheduled appointment.

If this appointment was scheduled with Dr. Benaissa, you will be required to pay the fee of **$75.00** and pre-pay the estimated out-of-pocket amount of your next visit. This amount is non-refundable.
All **cancellation** and **no show** appointments are documented in the chart and become part of your record. Patient initials: _____

Payment may be made via Cash, Check, Visa, MasterCard, Discover and American Express. There is a $30 + $5 bank fee for all returned checks.

I understand the above and agree that if full payment is not made within the two-month grace period, that I am responsible for any fees involved in the collection process, including, but not limited to, court cost and attorney fees in addition to the outstanding balance.

Patient Name_____

Patient signature: _____ Date: _____

AUTHORIZATION

YOUR SIGNATURE AT THE BOTTOM OF THIS PAGE INDICATES THAT YOU UNDERSTAND AND AGREE TO ALL OUR POLICES.

- I authorize and give consent to the performance of dental services for myself (or my dependent).
- I give consent to any necessary or advisable dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment. I understand that using anesthetic agents embodies certain risks.
- I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered.
- I authorize the use of this signature on all insurance submissions.
- I authorize the dentist to release all information necessary to secure the payment of benefits.
- I give this dental office the right to release any health information and x-rays relevant to my treatment to my insurance carriers, physicians or dental specialists that I may be referred to.
- I understand that I am financially responsible for payment of services rendered, regardless of insurance coverage.

Patient signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____ have received a copy of the Notice of Privacy Practices (attached behind)

Patient signature: _____ Date: _____

For Office Use Only:

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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 5/25/2010 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 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 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 $30.00 for each page, $00.00 per hour 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 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, 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 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. Walid Ben Aissa

Telephone: 617-928-9299 Fax: 617-928-0110

E-mail: newtonsmilecentre@gmail.com

Address: 796 Beacon Street, Newton, MA 02459