Welcome to Henniker Family Dentistry

K. Drew Wilson, DMD, MAGD - Joshua T. Osofsky, DMD - Michael Hochberg, DMD

Please take a few minutes to answer the following questions. Your answers will help us assist you with your healthcare needs.

About You

Name:____________________________________DOB:_______________SS#:____________
Address:__________________________________ City:______________ State/ZIP:__________
Home Phone:_________________________ Employer & Phone:_____________________________
Cell Phone:_________________________ E-mail address:________________________________

Are you willing to accept appointment confirmations by: **Text: Yes / No E-mail: Yes / No**

Additional Information

How did you hear about us? ____
I like to be called: _______________________ Marital Status: Single Married Divorced Other
Name of spouse: ___________________ Names of children: _____________________________
Person to contact in case of emergency: ____
Emergency phone number: ____
If you could wave a magic wand and change anything about your smile, what would you like to do?
____

Insurance

Name of primary benefit plan: __________________ Name of secondary insurance: ________________
Insurance company address: ___________________ Insurance Company address: _________________
____ ____
Phone #_________________________________ Phone#__________________________________
Group #_________________________________ Group #__________________________________
Policy #_________________________________ Policy #__________________________________
Policyholder's name: _________________________ Policyholder's name:______________________
Policyholder's birth date:_____________________ Policyholder's birth date:___________________
Policyholder's SS #:__________________________ Policyholder's SS#:________________________
Policyholder's Employer ______________________ Policyholder's Employer ___________________

I affirm that the information that I have given is correct to the best of my knowledge. It will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to provide the dental services I will need. I assign directly to Henniker Family Dentistry all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and am also responsible for paying any co-payment, deductible, or procedure that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits.

Signature:____Date:_________

PAYMENT IS DUE AT TIME OF SERVICE

05/25/2021

Medical & Dental History-*Personal and Confidential*

05/25/2021

Do you have any of the following diseases or medical conditions?

- ☐ Active tuberculosis / exposure to anyone with tuberculosis
- ☐ Persistent cough greater than a 3-week duration / cough that produces blood.

If you marked any of the above items, please stop and return this form to the receptionist.

Name of personal physician: ____
Address & phone #: ____
Approximate date of last visit: ____

Have you had any serious illness, operation or been hospitalized in the last five years? YES / NO
If yes, please explain: ____

Have you had any general health changes within the past year/are you being treated for a condition now?
YES / NO
If yes, please explain: ____

Dental Information:

Have you had periodontal treatment? Yes No
Do you wear dentures or partial? Yes No

Please check if you are allergic to any of the following:

☐ Local anesthetics	☐ Sulfa drugs	☐ Codeine/other narcotics
☐ Penicillin/other antibiotics	☐ Aspirin	☐ Latex sensitivity
☐ Barbiturates, sedatives, sleeping pills	☐ Other______________________	

Describe Reaction: ____

The following conditions **may require** a **pre-medication** with antibiotics. Please check if any of them apply to you (or have in the past)

☐ Prosthetic implant
Joint & date: ____________________

☐ Transplant surgery
Organ & date: ___________

☐ Artificial (prosthetic) heart valve

Prescription or Non-Prescription or Herbal Medications
List all medications and Herbal Supplements/Remedies that you are currently taking:

Name:______________________________Dose:______________________
Name:______________________________Dose:______________________
Name:______________________________Dose:______________________

Are you taking or scheduled to begin any Bisphosphonate Therapy such as Fosamax or Actonel? YES / NO
Since 2001, were you treated or are scheduled to begin treatment with intravenous Bisphosphonates (Aredia or Zometa) for bone pain, hypocalcemia or skeletal complications resulting from Osteoporosis, Paget's Disease, Multiple Myeloma or Metastatic Cancer? YES / NO

Have you been vaccinated against COVID-19? YES / NO Date:__________________________
Have you had any direct exposure to someone who has tested positive for COVID-19? YES / NO
Date of exposure? ____
Are you actively experiencing any of the following COVID-like symptoms:

☐ *Fever / flu-like symptoms* ☐ *cough / shortness of breath* ☐ *loss of taste/smell*

If you are experiencing any COVID-19 symptoms, please notify office personnel immediately.

PLEASE COMPLETE BOTH SIDES

Please circle YES or NO for any illness that your currently have or previously had.

HEART/BLOOD DISORDERS			**Date:**	**OTHER CONDITIONS**			**Date:**
Artificial Heart Valve	Yes	No		COVID-19 Diagnosis	Yes	No	
Congenital Heart Defect	Yes	No		Kidney Problems/Dialysis	Yes	No	
Heart Murmur	Yes	No		Liver Disease	Yes	No	
Angina	Yes	No		Artificial Joints	Yes	No	
Congestive Heart Failure	Yes	No		Type:	Date:		
Heart Surgery	Yes	No		Cancer	Yes	No	
Heart Attack	Yes	No		Chemotherapy	Yes	No	
Prosthetic Heart Valve	Yes	No		Radiation	Yes	No	
Pacemaker/Defibrillator	Yes	No		Persistent Swollen Glands	Yes	No	
Bacterial Endocarditis	Yes	No		Osteoporosis	Yes	No	
Coronary Artery Disease	Yes	No		Chronic Pain	Yes	No	
High Blood Pressure	Yes	No		Pregnant	Yes	No	
Hemophilia	Yes	No		Due Date:			
Anemia	Yes	No		Nursing:	Yes	No	
OTHER:				OTHER:			
RESPIRATORY/LUNG CONDITIONS				**INFECTIOUS DISEASE**			
Asthma	Yes	No		AIDS/HIV	Yes	No	
Emphysema / COPD	Yes	No		Hepatitis	Yes	No	
Chronic Bronchitis	Yes	No		Sexually Transmitted Infection	Yes	No	
History of Tuberculosis	Yes	No		OTHER:	Yes	No	
Active Tuberculosis	Yes	No					
OTHER:	Yes	No		**GI DISORDERS:**			
NEUROLOGICAL DISORDER:				Heartburn	Yes	No	
Epilepsy	Yes	No		GE Reflux	Yes	No	
Stroke	Yes	No		Ulcers / Gastritis	Yes	No	
Migraine	Yes	No		Eating Disorder	Yes	No	
OTHER:				Inflammatory Disease	Yes	No	
				OTHER:			
BEHAVIORAL CONDITIONS			**Date:**	**HORMONAL DISORDERS**			**Date:**
Mental Health Disorder	Yes	No		Diabetes: Type 1 Type 2	Yes	No	
Anxiety	Yes	No		Recent A1c:	Yes	No	
Panic Attacks	Yes	No		Thyroid Disorder	Yes	No	
Depression	Yes	No		Autoimmune Disorder	Yes	No	
Controlled Substance Abuse	Yes	No		Type:			
OTHER:				OTHER:			

Consent to Share Confidential Dental Information

To be valid this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient's Legal Name: ______________________________ Birth Date:____________________

I HEREBY AUTHORIZE FAMILY DENTAL CARE TO SHARE:

- ☐ Any of my medication/dental information
- ☐ Payment and Insurance Information
- ☐ My appointment times, dates and reason for visits
- ☐ The Medications I am taking

WITH THE FOLLOWING PEOPLE:

Full Name:________________________________Relationship__________________________

Full Name:________________________________Relationship__________________________

I understand that I may cancel this consent at any time (by writing to Henniker Family Dentistry), but that cancelling it will not affect any information that has already been released.
I understand that I do not have to sign this form, and that I should only sign it if I want my dental provider or my clinic to share my information with someone.
This authorization expires when I cancel it in writing.

Signature:____Date:________________________

Relationship to minor patient (if parent or legal guardian)*________________________________
If you are not the minor patient's parent, you must give us proof of guardianship (for example: a court order or power of attorney)

Witness:____Date:________________________

05/25/2021

Appointment Cancellation Policy

At Henniker Family Dentistry, we schedule individual time with each patient to deliver the quality personal care that each person deserves.
Our office policy requires that you give at least **48 hours'** notice when changing an appointment. Available appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely care.

Because your appointment time is a guaranteed reservation for you, a **$60 charge** will be required for the following conditions:

- Less than **48 hours'** notice for cancelling or rescheduling an appointment
- Missing an appointment without giving notice to our office

By signing below, you acknowledge that you have read and understand the cancellation policy for Henniker Family Dentistry

Thank you for your understanding.

Patient Signature: ________________________________ Date:______________

05/25/2021

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates, and their subcontractors may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

Records & Communication

- You can ask for an electronic or paper copy of your records and other health information we have about you. We will provide a copy or summary of your health information within 60 days of your request. We may charge a reasonable, cost-based fee.
- You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- You can ask for a list of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Choose someone to act for you:

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation
- Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures

We typically use or share your health information in the following ways:

- *We can use your health information and share it with other* professionals who are treating you.
- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues-

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety.

Work with a medical examiner or funeral director or respond to organ and tissue donation requests-

We can share health information with a coroner, medical examiner, or funeral director when an individual dies. We can share health information about you with organ procurement organizations.

Address workers' compensation, law enforcement, and other government requests-

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes/with a law enforcement official (If state or federal laws require it, including with the Dept. of Health and Human Services if it wants to see that we're complying with federal privacy law.)
- With health oversight agencies for activities authorized by law.
- For special government functions such as military, national security, and presidential protective services.
- In response to a court/administrative order or in response to a subpoena.

Our Responsibilities

- We will not use or share your information other than as described here unless you tell us we can in writing. If you change your mind at any time, let us know in writing.
- We are required by law to maintain the privacy and security of your protected health information.
- We will promptly inform you if a breach occurs that may have compromised the privacy of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- *We will never share any substance abuse treatment records without your written permission.*

Complaints

You may complain to us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint.

We will not retaliate against you for filing a complaint.

Jessica Bonenfant	***(603) 428-3419***	***hygiene@hennikerfamilydental.com***
HIPAA Compliance Officer	***phone***	***email***

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to:
200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775,
or visiting ***www.hhs.gov/ocr/privacy/hipaa/complaints/.***

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions about this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Acknowledgment of Receipt of the Notice of Privacy Practices

Name of patient or representative **Date**

Updated 05/25/2021