



PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you.

PERSONAL

Patient Name _____
Last First MI (Preferred)
Birthdate _____ SS# _____ DL# _____ Gender: ☐ M ☐ F Married: ☐ Y ☐ N
Work Phone _____ Cell Phone _____ Email _____

If patient is under 18 yrs, please also complete the following:

Guarantor Name _____
Last First MI (Preferred)
Birthdate _____ SS# _____ DL# _____ Gender: ☐ M ☐ F Married: ☐ Y ☐ N
Work Phone _____ Cell Phone _____ Email _____
Student status if dependent over 19 (for ins) ☐ Nonstudent ☐ Fulltime ☐ Part time
How did you hear about us? (Please be specific so we can thank them!) _____

ADDRESS AND HOME PHONE

Check circle if same for entire family: ☐
Address _____
Address 2 _____
City _____ State _____ Zip _____
Home Phone _____

INSURANCE POLICY 1

Patient relationship to subscriber: ☐ Self ☐ Spouse ☐ Child
Subscriber Name _____ Sub.ID # _____ Sub.DOB _____
Insurance Company _____ Phone _____
Employer _____ Group Name _____ Group # _____

INSURANCE POLICY 2

Patient relationship to subscriber: ☐ Self ☐ Spouse ☐ Child
Subscriber Name _____ Sub.ID # _____ Sub.DOB _____
Insurance Company _____ Phone _____
Employer _____ Group Name _____ Group # _____

Comments: _____

Please complete reverse side.

MEDICAL HISTORY

Name of Medical Doctor: _____ City/State _____

Emergency Contact _____ Phone _____ Relationship _____

List all the medications or drugs you are now taking:

Check medications or drugs you are allergic to:

[] None

☐ None

☐ Local Anesthetics

☐ Aspirin

☐ Metals

☐ Codeine/ Other Narcotics

☐ Penicillin

☐ Erythromycin

☐ Sulfa Drugs

☐ Latex Rubber

☐ Other: _____

Check any medical conditions you may have:

☐ None

☐ Diabetes

☐ Joint Replacement, Date of: _____

☐ AIDS/HIV

☐ Emphysema

☐ Kidney/Bladder Trouble

☐ Alcohol/Drug Abuse

☐ Epilepsy

☐ Liver Disease

☐ Anemia/Leukemia

☐ Fainting Spells/Seizures

☐ Low Blood Pressure

☐ Anorexia/Bulimia

☐ Fever Blisters/Herpes

☐ Mental Health Problems

☐ Arthritis

☐ Frequent Headaches

☐ Mitral Valve Prolapse

☐ Asthma/Hay Fever

☐ Frequently Dry Mouth/Sjogren

☐ Persistent Diarrhea

☐ Blood Clotting Problems

☐ Gall Bladder Trouble

☐ Rheumatic Fever

☐ Blood Transfusion

☐ Heart Attack/Stroke

☐ Rheumatic Heart Disease

☐ Bronchitis

☐ Heart Disease/Angina

☐ Sexually Transmitted Disease

☐ Cancer/Tumor or Growth

☐ Heart Murmur

☐ Sinus Trouble

☐ Cardiac Pacemaker

☐ Hepatitis/Jaundice

☐ Stomach Ulcers

☐ Chest Pain Upon Exertion

☐ High Blood Pressure

☐ Thyroid Problems

☐ Damage Heart Valve

☐ Hives/Skin Rash

☐ Tuberculosis

☐ Other: _____

WOMEN ONLY- Are you PREGNANT or do you have reason to believe you may be? ☐ YES / ☐ No

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit: _____ Are you in pain? Yes / No

New patients:

Name of former dentist _____ City/State _____

Date of last cleaning and exam _____

FINANCIAL AGREEMENT

* For my convenience, this office may release my information to my insurance, and receive payment directly from them.

* With or without insurance, if sent to collections, I agree to pay a **\$30 collection fee**, all related fees and court costs.

* Every effort will be made to help me with my insurance or other financial arrangements, but if they do not pay as expected, I will still be responsible for any balance due.

* Treatment plans may change, and I will be responsible for the work actually done.

By signing below, I certify that all of the above information is true to the best of my knowledge, and agree to financial responsibility for all work completed.

(print) Patient Name or Guardian Name

Date

(sign) Patient Signature or Guardian Signature

APPOINTMENT POLICY

We are pleased that you have chosen **Pristine Dental** to take care of your dental health. In order to provide the best possible care, we would like you to understand our appointment policy. Your cooperation in following our appointment policy is imperative in making sure that we to keep your wait time to minimal, provide better appointment times for you, as well as making sure that if you need immediate treatment, we will be able to provide for you in timely manner. We ask that you try to keep your appointment whenever possible as delayed in care is never optimal when it comes to your dental health.

(Initial)_____ **Appointment Confirmation:** Any appointment **not confirmed in 24 hours** may be cancelled to allow other patient in need of immediate treatment.

(Initial)_____ **Cancellations:** we understand that due to illness or other unexpected event that it may be necessary for you to occasionally cancel an appointment. If for any reason you must cancel an appointment, **please notify our office staff at least 24-hours in advance** to reschedule. If you are unable to give 24 hour notice, please call our office as soon as possible and provide a reason for the cancellation. You can leave a message if you reach voicemail. Patient will be dismissed from our office after **3 Cancellations without 24 hour notice.**

(Initial) _____ **No shows:** Patient who do not show for their scheduled appointment, or do not call within 1 hour prior to scheduled appointment time, may result in cancellation of all future appointments. Please call to make sure your next appointment is still available. Patient will be dismissed from our office after **2 No Shows without any notice.**

(Initial) _____ **Lateness:** We expect all patient to arrive on time for their scheduled appointments. We may reschedule treatment for patients who arrive more than 10 minutes past their scheduled appointment time

(Initial)_____ A broken appointment is a loss to three people- The patient who missed the valuable time; the patient who could have taken the valuable time; and the doctor who was fully staffed and prepared for the appointment. A **\$50 fee** may be assessed to your account for **cancellation without 24 hour notice or no show**. All cancellation fees must be paid prior to scheduling another appointment.

Patient Name

Patient/Patient Rep Signature

Date

Relationship to patient

Notice of Privacy Practices

How we protect your information and privacy (updated 01/01/2020)

We take your privacy very seriously and as such we want to share with you how we handle your information.

Your Rights:

*You can get an electronic or paper copy of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable fee.

*You can ask us to correct your medical record

You can ask us to correct health information about you that you think is incorrect or incomplete. Please know that our practice management software does not allow us to make any changes after the date of service. We will make an entry of your request but we are unable to actually make any changes.

*You may request confidential communications

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 may ask us to limit what we use or share

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. **MINORS:** In the case of a minor child where the parents are divorced, unless otherwise advised by written court order or divorce decree, we will assume that each parent has the authority to authorize treatment, receive information regarding the child’s treatment, can make appointments for the child, as the natural parent of the child. The parent that brings the child will also be responsible for any financial payments due at the time of service. If we are provided a copy of the divorce decree we will abide by that order. We may or may not advise the other parent that a request for information has been made.

*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 benefit provider.. We will say “yes” unless a law requires us to share that information

*You may get a list of those with whom we’ve shared information

You can ask for a list (accounting) 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 healthcare 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 fee if you ask for another one within 12 months.

* You may get a copy of this privacy notice

You may receive a written copy of this notice

* You may 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.

* You may file a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting us or by contacting the Office of Civil Rights www.hhs.gov/ocr/privacy/hipaa/complaints

Your Choices:

In certain situations, or conditions, you can tell us your choices about what we can share. If you have a clear preference for how we share your information in the situations described below, talk to us and let us know. 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 family or close friends involved in your care.
- Share information in a disaster relief situation

If you are not able to tell us your preference or in the event of an emergency, we may go ahead and 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.

***We will never share your information for:**

- *Marketing purposes
- *Fundraising purposes

Our Uses

*We use your information to treat you

We can use your health information and share it with other professionals who are treating you including other dentist and healthcare professionals such as medical physicians, emergency personnel etc.

*Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary and as necessary. This includes providing information to labs. We can also contact you via telephone, cell phone, leave a message and through text messages.

*We can bill for our services We can use and share your health information to seek payment from health plans, benefit providers or other entities

How else we can use your information?

We are may also use your information in other situations or ways that usually affect the public good.

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

- *Preventing diseases
- *Helping with product recalls
- *Reporting adverse reactions to medicines
- *Reporting suspected abuse, neglect, or domestic violence
- *Preventing or reducing a serious threat to anyone's health or safety.
- * Research purposes
- *To comply with state or federal laws
- *To respond to a court order or subpoena
- *Share with coroner or medical examiner or funeral home
- *In the event of an emergency or disaster *Workers Compensation Claims
- *For law enforcement purposes
- *For special government functions such as military or national security

Our Responsibilities

We take patient privacy very seriously and attempt to take every precaution and safeguard to protect our patient's health information. However, if we find that there has been a breach or misuse of your information, we will notify you as soon as possible that your information may have been compromised or misused.

Our Privacy and Security Officer is:

Dr. Donghyun Noh, DMD
555 Providence Highway, Unit 2,
Walpole, MA 02081
(508) 734-7056

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.

Name of Patient (or parent if under 18 years)

Patient Name (printed)

Signature of Patient (or guardian if under 18 years)

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however, 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)

