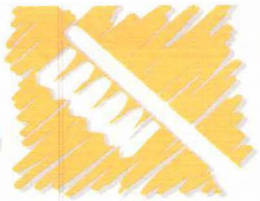



Welcome




We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____ Phone (___) _____ Alt. Phone (___) _____

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for ____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (___) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (___) _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (___) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (___) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (___) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (___) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Please Complete Both Sides

Dental History

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of Last Visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

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

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

ALLERGIES

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to

Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

Londonderry Dentistry & Implants
75 Gilcreast Rd., Unit 108
Londonderry, NH 03053
(603) 434-9329

Financial Policy

Thank you for choosing Londonderry Dentistry & Implants for your dental needs. In an effort to provide quality care to our patients and to avoid any misunderstandings, we would like to inform you of our office policy regarding payment for services rendered.

Payment is expected at the time treatment is performed. As a courtesy to our patients with dental benefits, we will submit your claim to your insurance company. Any portion not expected to be covered by these benefits is the ***responsibility of the patient and due at the time the service is rendered***. This amount will include deductibles and estimated cost share (co-payment) for treatment. If benefit amounts are less than expected, you will be billed for the difference and payment is due within 30 days.

Dental benefits are contracts between **the *policyholder* and the *insurance company***, not our office. We will make every effort to assist you with any benefit questions, however we highly recommend that you be aware of what benefits you have available. Ultimately, you are responsible for any account balance.

Marital status is not a consideration under any circumstance. Decreed custody or lack thereof, does not alter financial responsibility. The parent accompanying the child/minor on the day of service will be considered the responsible party. We will gladly provide you with copies of statements, which you may need to provide the other parent for reimbursement.

There is a **$35.00** charge for returned checks. If a check is returned and not paid within 14 days of return date, legal action may be taken for collection. Any costs associated with collection of returned checks will be assumed by the patient.

In the event your account becomes delinquent, a late charge of 1.5% will be assessed each month. Failure to keep your account current may result in not being able to receive additional dental services except for emergencies and prepayment requirements for services. You will be responsible for collection fees, attorney fees and court costs. Delinquent accounts transferred to collection will be assessed a fee up to 40% of the unpaid balance.

We accept: Cash, Check, Visa, MasterCard, and Discover. We also offer payment plans for your convenience with CareCredit as well as Lending Club. Please ask our staff for details on different finance options.

Broken Appointment Policy

(Effective 8/1/2019)

When you reserve a time with us please make every attempt to make your appointment as this time is set aside specifically for you. When a patient does not show up for their appointment or cancels too close to their scheduled time, we are often unable to fill this appointment time with other patients who are also in need of dental care. This policy is our attempt to ensure that both you and our other patients have the opportunity to receive the dental care needed.

Patients are allowed **ONE** broken appointment at no charge because we do understand that emergencies happen. A second broken appointment will incur a minimum charge of **$75.00 PER HOUR** which is the patient's financial responsibility as dental insurance will not cover broken appointment fees.

- Broken appointments are any time you are scheduled for an appointment and you do not show up for that appointment.

- Late cancelations are also considered broken appointments. If you need to cancel your appointment, we ask that you please call us **at least 24 hours before your appointment time**.

- Repeat broken appointments will force the office to place you on a "**Same Day Only**" status which would mean that you can call our office the day you have availability and we will check our schedule to see if we can accommodate you with an appointment time for that same day.

Appointment Confirmation: Our office offers a variety of confirmation methods including phone call, text, or email. Please be sure to update your preferences with our Office Manager (at the front desk). It is your responsibility to respond to our call, text, or email indicating you will be on time for your scheduled appointment.

Late Arrival to Appointment: If you arrive late to your scheduled appointment, it will be at the discretion of the provider if he/she can still accommodate you. Priority will be given to patients who arrive on time and you may have to be worked on in between them. One or two late patients cause the entire daily schedule to fall behind.

Patient Safety: You may be asked to present a current identification so we may make a copy for your record. This is to help prevent identity theft and insurance fraud.

Health history forms are required to be updated yearly. A health history update should be completed at least once a year, or whenever the patient has had any changes to their medical history.

Records Release: Londonderry Dentistry and Implants will be glad to forward your records upon your written authorization that should include the name, address, and email address of your new provider. Digital radiographs (x-rays) and Periodontal charting may be forwarded to another dentist via email at no charge.

Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices. By signing below, you understand and accept the terms of our Financial Policy, Broken Appointment Policy, and acknowledge receipt of our Notice of Privacy Practices.

Signature of Responsible Party _____ Date _____

NOTICE OF PRIVACY PRACTICES

Londonderry Dentistry & Implants
Dr. Tresa Mathew
Dr. Samson Nadar
75 Gilcreast Rd., Unit 108,
Londonderry, NH 03053
Phone 603.434-9329
kay@londonderrydentistryandimplants.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

Treatment, Payment, and Health Care Operations

The most common reasons why we use or disclose your health information is for treatment, payment, or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before our office. Examples of how we use or disclose health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative managerial functions that we have to do in order to run our office. Examples of how we disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for written permission.

Uses and Disclosures for Other Reasons Without Permission

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our offices at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence;
- Uses and disclosures for health oversight activities, such as for the licensing of doctors, for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- Disclosures for judicial or administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;

- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- Uses or disclosures for health related research;
- Uses or disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- Disclosures of de-identified information;
- Disclosures relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

Appointment Reminders
We may call, text, email, or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our offices that might help you. Unless you tell us otherwise, we may mail you an appointment reminder on a post card, and/or leave you're a reminder message on your home answering machine or with someone who answers your phone if you are not home.

Other Uses and Disclosures
We will not make any other uses or disclosures of your health information unless you sign a written "authorization form". The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea, and sometimes you may initiate the process if it is your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign the authorization form, you may revoke it at any time unless we have already acted in reliance upon it. Revocations MUST be in writing and be sent to the office manager.

Your Rights Regarding Your Health Information
The law gives you many rights regarding your health information. You can:

- Ask us to restrict our use and disclosures for purposes of treatment (except emergency treatment), payment or health care options. We do not have to agree to so this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office manager at the address or email shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using Email to your personal Email address. We will accommodate these requests if they are reasonable, but please be advised that they are subject to additional cost. If you want to ask for confidential communications, send a written notice to the office manager at the address or email shown at the beginning of this Notice.
- Ask us to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off

site). You may have to pay for photocopies in advance. If we deny your request, we will send a written explanation and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of time for the office to provide access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office manager at the address or email shown at the beginning of this Notice

- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from the date of your request. We will send the corrected information to persons who we know received the incorrect information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included with your health information, we will send it along any time we make a permitted disclosure. By law, the office can have one 30 day extension of time to consider your request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request to the office manager at the address or email shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or shorter period if you prefer). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, the office does charge a fee in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office manager at the address or email shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional copies, send a written request to the office manager at the address or email shown at the beginning of this Notice.

Our Notice of Privacy Practices

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, and have copies available as well as posting it on our website.

Complaints

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the US Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to file a complaint with us, send a written request to the office manager at the address or email shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone,

For More Information

If you want more information about our privacy practices, call or visit the office manager at the address or email shown at the beginning of this Notice.

Acknowledgement of Receipt

I acknowledge that I have received a copy of this office's Notice of Privacy Practices

Patient Name: _____

Signature: ______________________________________ Date: ___________________________