# PATIENT INFORMATION

*Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.*

**Patient's name** _____ Preferred name _____ Birth date_____

If minor, parents names _____ Cell phone _____ Home phone _____

Mailing address _____ City _____State _____ Zip _____

How did you hear about our office? _____ ❑ Mailer

**Email Address**:

_____

**INSURANCE INFORMATION:** ❑ Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co._____ Group number_____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's name _____ Spouse's employer _____

Spouse's birthday _____ _____ Social Security number _____

## MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Do you need to premedicate for dental appointments?

- ❑ Yes
- ❑ No

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocaine")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____

_____

_____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

**Name of your Physician**:_____

**Emergency Contact:**_____

Do you have any disease, condition, or problem not listed above?_____

_____

Please add anything else you would like us to know about:_____

**Signature of patient (or parent)** _____ **Date** _____

Paul Mathew, D.D.S.
ARTISAN DENTISTRY
Striving for Excellence

Artisan Dentistry, PLLC
One Stiles Road, Suite 102 Salem, NH 03079
603-890-4004 Phone
28 Green Street, Newburyport, MA 01950
978-358-8576 Phone

## CANCELLATION POLICY

Whether you have scheduled an appointment with Dr. Mathew or with our hygienist, we have reserved time for you in their schedule. It is extremely important that you come in for your appointment. Should a conflict arise and need to cancel/reschedule your appointment, we do require a 48 hours notice courtesy call. We reserve the right to charge a fee for missing your appointment and/or cancelling with less than 48 hours notice. You can always leave a message with the answering service if the office is closed.

## OFFICE FINANCIAL POLICY

1. Payment is due in full at the time of service for patients who do not have dental insurance. An estimated co-payment is collected at the time of service for any restorative work done for those patients who do have dental insurance. We cannot guarantee the amount your dental benefit plan will pay, however we can give you an estimate based on what many insurance companies pay based on traditional plans. Following payment by your insurance, a bill will be sent from our office for any remaining balance.
2. We do accept VISA, Master Card, DISCOVER, American Express personal checks and cash.
3. We provide a 5% courtesy for Cash and Check payments
4. We do not provide in-office payment plans, however, we do offer financing through Care Credit and Lending Club.

## AUTHORIZATION & RELEASE

To the best of my knowledge, the information provided is complete and accurate. I understand that it is my responsibility to inform the office if I, or my minor child, have any changes in health.

I and/or my dependent(s) assign all insurance benefits to Artisan Dentistry, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize the use of my signature on all insurance claim submissions. Artisan Dentistry may use my health/dental care information and may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payment for services rendered and for determining insurance benefits

**By signing below, I understand and will comply with the payment and cancellation policies as discussed.**

**Patient Signature: _____ Date: _____**

**Signature of guardian or parent if patient is under the age of 18: _____**

**Date: _____**

Paul Mathew, D.D.S.
ARTISAN DENTISTRY
Striving for Excellence

1 Stiles Road, Suite 102 Salem, NH 03079
603-890-4004

28 Green St. Newburyport MA, 01950
978-358-8576

# ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Dr. Paul Mathew-Artisan Dentistry's Notice of Privacy Practices, which has an effective date of 02/1/2014, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been offered a copy of the Notice of Privacy Practices:

_____ _____

**Signature of Patient or Patient's Representative** **Date**

_____ _____

**Print Name** **Relationship to patient (If not signed by Patient)**

HIPAA Release Information

| I authorize the release of any and all information including diagnosis, financial, dental records, examinations rendered to me and claims information. This information may be released to: | |
|---|---|
| € Spouse: | € Child(ren) : |
| € Other: | € Information is not to be released to anyone. |
| Best time to reach me: | € AM ☐ PM |

I understand the office will try and accommodate my wishes about my contact information, but may have to contact me at the other numbers provided if unable to contact me at my requested number/location

**Dental Health History**

1. What prompted you to come to our office? _____

2. When was your last dental appointment? _____

3. Have you experienced any of the following conditions/problems?

| | | |
|---|---|---|
| ☐ Bleeding | ☐ Clicking/Popping in Jaw | ☐ Ringing in Ears |
| ☐ Bad Breath | ☐ Hard to Open Wide | ☐ Tingling in Finger tips |
| ☐ Sensitivity to Hot & Cold | ☐ Soreness in Jaw | ☐ Pain in joints |
| ☐ Food Catching Between Teeth | ☐ Clenching/grinding Teeth | ☐ Pain in Ears |
| ☐ Snoring | ☐ Shoulder/Neck Pain | ☐ Pain in side of Face |
| ☐ Currently Wearing Dentures Or Partial | ☐ Headaches | |

4. What is the biggest barrier to seeing a new dentist for the first time?
_____

5. If you could change anything about your smile which of the following would you want?

| | | |
|---|---|---|
| ☐ Whiter | ☐ Close Space/Spaces | ☐ Fix chipped/broken Teeth |
| ☐ Replace Missing Teeth | ☐ Replace Old Crowns | ☐ Remove Silver Fillings |
| ☐ Remove Stains/Spots on Teeth | ☐ Excess Showing of Teeth | ☐ Straighten Teeth |
| ☐ Less Gum Showing | ☐ Reshape/Resize Teeth | ☐ Other |

6. Together, what goals would you like to achieve for your oral health care?
_____

7. In presenting your treatment plan and talking to the doctor please let us know which is best for you.
____ I like lots of information and details ____ I like just the basics and facts

8. Please let us know which is most important to you when making your dental health decision. Number from 1 to 5 in order of importance ****__1__ being the most important and __5__ being least important****

_____ Quality of Care
_____ Comfort of Care
_____ Finances and Budget
_____ Time
_____ Relationship with Doctor and Staff

**Patient Signature: _____ Date: _____**

# 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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 1, 2014 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request. It can also be found on our website; www.drpaulmathew.com

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.

## HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

**Treatment**: We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

**Payment**: We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

**Individuals Involved in Your Care or Payment for Your Care**: We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

**Disaster Relief**: We may use or disclose your health information to assist in disaster relief efforts.

**Required by Law**: We may use or disclose your health information when we are required to do so by law.

**Public Health Activities**: We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

**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 the protected health information of an inmate or patient.

**Secretary of HHS**: We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker's Compensation**: We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.
**Law Enforcement:** We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.
**Health Oversight Activities**: We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.
**Judicial and Administrative Proceedings**: If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.
**Research**: We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.
**Coroners, Medical Examiners, and Funeral Directors**: We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.
**Fundraising**: We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

## Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

## Your Health Information Rights

**Access**: You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.
If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.
**Disclosure Accounting**: With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.
**Right to Request a Restriction**: You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.
**Alternative Communication**: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in **Writing**: Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.
**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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.
**Right to Notification of a Breach**: You will receive notifications of breaches of your unsecured protected health information as required by law.
**Electronic Notice**: You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).
**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 if 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.

Our Privacy Official: Dr. Paul Mathew

Telephone: 978-358-8576

Address: 28 Green St. Newburyport, MA

E-mail: drpaulmathew.com