1212 Putney Rd., Brattleboro, VT 05301
(802) 254-9244
info@horizondentalvt.com

☐

Please check the box next to your office of choice.

☐

206 Heater Rd., Lebanon, NH 03766
(603) 448-1940
frontdesk@horizondentalnh.com

Today's Date

Registration Information

The following information will make it possible for us to be more successful and thorough in your treatment. Your answers are for our records only and will be considered confidential.

Name | Birth Date

Preferred Name

Address

City | State | Zip Code

Home Phone | Cell | Work Phone | Ext

Email ☐ I would like to receive correspondence by email

Employment Status | Profession

Employer

Current Student? | Other Studies?

Age | Sex | Social Security Number

Marital Status | Spouse Name

Contact Name | Contact Phone

Who may we thank for referring you?

Do you have an out-of-town address? ◯ Yes ◯ No If yes, which months are you away?

☐ J ☐ F ☐ M ☐ A ☐ M ☐ J ☐ J ☐ A ☐ S ☐ O ☐ N ☐ D

Out-of-Town City and State | Out-of-Town Phone

Who will pay this Account?

Insurance Carrier Name

Insurance Group Number

Patient:

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you allergic to any of the following? ◯ Yes ◯ No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics (Dental) ☐ Other

If Other, please list: _____

Women, are you ☐ Taking oral contraceptives? ☐ Pregnant/Trying to get pregnant? ☐ Nursing?

Do you have, or have you had any of the following? ◯ Yes ◯ No

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/GI Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pacemaker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had a serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Do you take Bisphosphonate Drugs, i.e. Actonel and Fosamax? ◯ Yes ◯ No

Current Medicines and Supplements: _____

Preferred Pharmacy _____

Pharmacy Location and Phone _____

Patient:

Medical History continued

Physician 1 | Phone

Physician 2 | Phone

Physician 3 | Phone

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain:

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain:

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Is there anything else we should know in order to help provide you with the best possible care?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian

Date

Patient:

Dental History

Patient First and Last Name

Reason for this Visit?

Date of Last Dental Visit

Have you had any difficulty with dental treatment in the past? ◯ Yes ◯ No

How often do you brush your teeth?

How often do you floss?

What other oral hygiene aids do you use?

Do your gums bleed while brushing or flossing?

Do you have tooth or gum pain with ☐ Hot ☐ Cold ☐ Sweet ☐ Biting Explain

Do you have a history of bite problems? ◯ Yes ◯ No Explain

Do you have a history of headaches? ◯ Yes ◯ No Explain

Do you clench or grind your teeth? ◯ Yes ◯ No Explain

Do you have a history of broken teeth or fillings? ◯ Yes ◯ No Explain

Do you have a history of periodontal disease? ◯ Yes ◯ No Explain

On a scale of 1 to 10, with 10 being highest, what priority do you give your teeth and oral health?

What goals do you have with your teeth and oral health?

What current dental concerns do you have?

Are you happy with the appearance of your teeth and smile?

If you could change anything about your mouth or smile, what would it be?

What did you like best about your former dental office?

What did you like least about your former dental office?

Patient:

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's in effect. This Notice takes effect 06/24/03 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 reason- able 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, texts, 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 $3 for each page, $15 per hour for staff time to locate and 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 1, 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.

Brattleboro Office:
Contact Officer: Stacy Kramer
Telephone : (802) 254-9244
Fax: (802) 254-3820
Address: 1212 Putney Rd., Brattleboro, VT 05301
E-mail: stacy@horziondentalvt.com

Lebanon Office:
Contact Officer: Kathy Fowler
Telephone: (603) 448-1940
Fax: (603) 448-1228
Address: 206 Heater Rd., Lebanon, NH 03766
E-mail: frontdesk@horizondentalnh.com

Your Privacy Is Important To Us

Acknowledgement of Receipt of Notice of Privacy Rules

I have received a copy of the Notice of Privacy of Horizon Dental Associates. I hereby authorize, as indicated by my signature below, Horizon Dental Associates to use and disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication:

- ☐ You may contact me at my mobile telephone number _____
- ☐ You may send me an unencrypted email/text at: _____
- ☐ You may contact me at my home telephone number _____
- ☐ You may contact me at my work telephone number _____
- ☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added/Removed: _____
2. _____ Date Added/Removed: _____
3. _____ Date Added/Removed: _____
4. _____ Date Added/Removed: _____

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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) _____

Staff Person Initials _____

GENERAL TREATMENT CONSENT

Please read the following consent form carefully and we encourage you to ask us anything that you do not understand. We will be glad to explain it to you.

I thereby authorize and direct Horizon Dental Associates to perform **dental treatment** on me, which includes any necessary local anesthesia, radiographs or diagnostic aids such as photographs or dental models. I understand that none of the procedures listed below will be performed without first obtaining my verbal consent. I also understand that alternative methods of treatment, if any, along with their advantages and disadvantages will be explained to me. In general terms, **dental treatment** authorized may include one or a number of the following:

Local Anesthetic
Dental prophylaxis and application of topical fluoride
Treatment of periodontal disease
Application of sealants to the grooves of teeth
Treatment of diseased or injured teeth with composite filling material
Replacement of missing teeth with implants, bridges, partials or dentures
Extraction of one or more teeth
Treatment of diseased or injured oral tissues (hard and/or soft)
Treatment of miss-aligned teeth
The use of sedative medications to control apprehension and anxiety

I am advised that good results are expected in general, however the possibility of complications cannot be accurately anticipated. Therefore, no guarantee, expressed or implied, can be given to me regarding any treatment. I fully understand and authorize Horizon Dental Associates to perform any necessary treatment that is in their judgment as long as it is in my best interest and that I have been advised of my financial obligation. I understand that there are some risks in the administration of local anesthetics. Most risks are related to the position of the nerves under the tissue at the site of the injection, which cannot be determined prior to the administration of the anesthetic agent. Although the risks seldom occur, they may include loss of, or disturbed sensation of the tongue and lip on the side of the injection. If this occurs, it is often temporary, and normal sensation usually returns in several days. However, in very rare cases, the loss of sensation may extend for a longer period and may become permanent. In addition, injecting a foreign substance into the body such as an anesthetic agent may result in an allergic reaction. Allergic reactions to these agents are rare, but may take place. I also understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the gums or teeth that were not discovered during examination (the most common being the need for root canal therapy following routine restorative procedures).

FINANCIAL POLICY

You will be fully informed about treatment fees and/or financial arrangements prior to treatment. Once treatment has begun, if changes are necessary, you will be informed and given the opportunity to continue treatment, change treatment, or cancel treatment. Full payment is due at the time of treatment. This includes, if applicable, deductibles, co-pays, and non-covered charges. Delinquent accounts are subject to submission to a collection agency, attorney or small claims court. Any interest charges, attorney fees, or court costs will be the responsibility of the patient (or responsible party).

INSURANCE COVERAGE

Dental insurance is a contract between your Employer who selects your coverage limits and the insurance company. You (the Subscriber) receive benefits as defined by the plan. We can not guarantee the insurance carrier will make payments based upon Horizon Dental's reimbursement estimates. ***Please be aware***, you are responsible for all dental fees your insurance carrier has not paid. We estimate insurance coverage to the best of our ability. As a general rule, insurance does not cover 100% of all services. Your insurance is a benefit designed to provide assistance; not full payment. Deductibles and co-payments are the patients' responsibility and are expected at the time of service. We will assist you in maximizing your dental insurance by providing an estimate of coverage, filing insurance claims to your insurance carrier, and if applicable, accepting assignment of benefits.

APPOINTMENT POLICY

Because the time of your appointment has been reserved specifically for you, we request notice be given 48 hours in advance for any changes to your appointment. Cancellations without a valid reason (or failure to show up) within 24 hours are subject to a service fee of $75.00 per scheduled hour.

I certify that I have read and fully understand this consent. I have been given the opportunity to ask questions regarding this consent. I also understand that this consent will remain in effect until such time I choose to terminate my relationship with the office and I have advised them of such termination.

_____ _____

Patient (or guardian) Signature Date