

WELCOME TO CASELLE DENTAL, LLC - TELL US ABOUT YOURSELF

Patient's Name _____ Date _____
Last First MI

Preferred Name _____ Male Female Married Single Child Other

Address _____ City _____ State _____ Zip _____

Social Security # _____ Birth Date _____ E-mail _____

Phone (Home) _____ (Work) _____ Ext _____ Cell Phone _____

Employer Name _____ Occupation _____

Address: _____
Street City State Zip

Preferred contact for appointment confirmation: Home Phone Cell Phone Email Text Work Phone

Emergency Contact: Name: _____ Phone: _____

◆ Person Responsible for Payment (if other than patient)

Name: _____ Male Female Married Single Other _____

Social Security # _____ Birth Date _____ E-Mail _____

Phone (Home) _____ (Work) _____ Ext: _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Employer Name _____ Occupation _____

Address: _____
Street City State Zip Code

◆ Insurance – Primary

Name of Insured _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date _____ ID # _____ Group # _____

Insured's Address _____ City _____ State _____ Zip _____

Insured's Employer Name _____

Address _____

Patient's relationship to insured Self Spouse Child Other _____

Insurance Plan Name and Address _____

◆ Insurance – Secondary

Name of Insured _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date _____ ID # _____ Group # _____

Insured's Address _____ City _____ State _____ Zip _____

Insured's Employer Name _____

Address _____

Patient's relationship to insured Self Spouse Child Other _____

Insurance Plan Name and Address _____

Medical History

Do you have or have you ever had any of the following? Please check those that apply.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fainting | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Cough that produces blood |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Been exposed to anyone with Tuberculosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sexually Transmitted Disease | |
| <input type="checkbox"/> Artificial Joints _____ | <input type="checkbox"/> Heart Murmur | Type _____ | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Shingles | Allergies To Medications |
| <input type="checkbox"/> Blood Transfusion _____ | <input type="checkbox"/> Hepatitis – Type _____ | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problems | Women only: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tuberculosis | Due Date _____ |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Migraines | Date _____ | Are You Nursing? _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mitral Valve Prolapse | | Are Taking Birth Control Pills? _____ |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pacemaker | | |
| <input type="checkbox"/> Facial Surgery | <input type="checkbox"/> Psychiatric Problems | | |

- Do you use tobacco (smoking, snuff or chew)? Yes No If yes, how much? _____
- Do you drink alcoholic beverages? Yes No If yes, how much alcohol do you typically drink in a week? _____
- Do your gums bleed when you brush or floss? Yes No How often do you brush?: _____ How often do you floss?: _____
- Are your teeth sensitive to cold, hot, sweets or pressure? Yes No • Do you brux or grind your teeth? Yes No
- Name of your Primary Care Physician _____ Phone _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Do you have any health problems that need further clarification or were not listed above? Yes No
If yes, please explain: _____
- List any medications you are taking (if none write NONE): _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I agree to inform the doctor at the next appointment.

Signature of patient, parent or guardian _____ Reviewed by _____ Date: _____

How did you hear about our office? Another patient Internet Insurance Company Dental Office Verizon Yellow Pages Community Yellow Pages Newspaper Work Other _____

Name of person or office referring you to our practice _____

- Date of Last Dental Visit _____ Reason for this visit _____
- If you could change one thing about your smile what would it be? _____
- Why did you leave your last dentist? _____
- What did you like most about any dentist you have ever seen? _____
- Have you ever had any complications following dental treatment? Yes No If yes, please explain: _____

Financial Policy & Authorizations

- As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the costs incurred in their care and the financial responsibility on the part of each patient must be determined before treatment.
- All emergency dental services or any dental services performed without previous financial arrangements must be paid for at the time services are performed. We accept MasterCard, Visa, American Express, Discover, cash, and checks. If you are in need of an extended finance option, we work with CareCredit, which offers short term interest free programs or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit. Ask for details.
- If you have a Dental Plan please know that it is designed to help you pay for a portion of the cost of your dental care. Therefore, patients who have dental insurance should understand that all dental services provided are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Our office will prepare insurance forms and assist in obtaining payment from your insurance company on your behalf and will credit any such payments to your account. Please understand our dental office cannot render services on the assumption that our charges will be paid by your insurance company.
- Insurance eligibility and benefits quoted are not a guarantee, they are subject to change. We will provide you with an estimate of your co-payments and deductible based on your insurance coverage which is payable at the time of your visit. This ESTIMATE IS NOT A GUARANTEE of the final amount of benefits to be paid by your insurance company. The final amount of benefits to be paid will be determined by your insurance company only after they receive the dental claim. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for all of your dental care. It is only meant to assist you.
- The amount your plan pays is determined by the agreement negotiated by your employer with the insurer and by how much your employer contributes to the plan.
- As a service to you, we will submit your dental claims to your insurance company. Keep in mind that dental plans are designed to share in the cost of your dental care, not to completely pay for those costs. Please ask for "Why Doesn't My Insurance Pay for This?" pamphlet at the front desk which will answer any other questions you may have about dental insurance
- I further agree to pay for all services rendered regardless of anticipated insurance benefits within 30 days of the date of service and agree to pay all reasonable attorney fees or collection costs associated with non-payment of an account balance.
- A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days regardless of anticipated insurance payments.
- I authorize the release of any information including the diagnosis and records of treatment or examination rendered to either myself or a dependent to my insurance company and/or healthcare practitioner. I authorize and request that my insurance company pay directly to the doctor insurance benefits otherwise payable to me.
- **I have read and understand the above Financial Policy and Authorizations. I acknowledge receipt of this office's Notice of Privacy Practices.**

▶ _____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or legal representative

▶ _____ Date: _____ Relationship to Patient: _____
Signature of person responsible for payment other than patient

CASELLE DENTAL, LLC.

NOTICE OF PATIENT PRIVACY PRACTICES

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

If you have any questions about this Notice, please contact our Privacy Officer at the number listed at the end of this Notice.

Each time you visit a healthcare provider; a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This Notice applies to all of the records of your care generated by your health care provider.

Our Responsibilities

Caselle Dental, LLC. is required by law to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information. The current Notice will be posted at the front desk and on our website at www.caselledental.com. The notice will include the effective date. In addition, we will make our best effort to provide you with a copy of this notice and we request that you acknowledge receipt with your signature.

We are required by law to abide by the terms of this Notice and provide you with a new Notice if we make changes to this Notice, which may be at any time. Changes to the Notice will apply to your medical information that we already maintain as well as new information received after the change occurs. If we change our Notice, it will be available to anyone who asks for it, and posted at the front desk and on our website at www.caselledental.com. You may also request that a revised Notice be sent to you in the mail or you may ask for one at your next appointment or appropriate visit. This Notice will also serve to advise you as to your rights with regard to your medical information.

How We May Use and Disclose Medical Information About You.

The following categories describe examples of the way we use and disclose medical information:

1. **For Treatment:** We may use medical information about you to provide, coordinate, and manage your treatment or services. We may disclose medical information about you to other doctors, nurses, technicians (e.g. clinical laboratories or imaging companies), medical students, or other personnel who are involved in your care. We may communicate your information either orally or in writing by mail or facsimile.

We may also provide a subsequent healthcare provider with copies of various reports that should assist him or her in treating you. For example, your medical information may be provided to a physician to whom you have been referred to ensure that the physician has appropriate information regarding your previous treatment and diagnosis.

2. **For Payment:** We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company, or a third party payer. For example, we may need to give your insurance company information before it approves or pays for the health care services we recommend for you.
3. **For Health Care Operations:** We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to quality assessment activities, employee review activities, licensing, legal advice, accounting

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support, information systems support and conducting or arranging for other business activities. In addition, we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment by telephone or reminder card.

4. **Business Associates:** There are some services provided in our organization through contracts with business associates. Examples include cleaning services, collection services, quality assurance, and software support. If these services are contracted, we may disclose your health information to our business associate so that they can perform the job that we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information through a written contract. In addition, business associates are individually required to abide by the HIPAA Rules.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent. Authorization or Opportunity to Object

We also may use and disclose your health information as set forth below. You have the opportunity to agree or object to the use or disclosure of all or part of your health information in these instances. If you are not present or able to agree or object to the use or disclosure of the health information (such as in an emergency), then your clinician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

1. **Individuals Involved in Your Care or Payment for Your Care:** Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.
2. **Future Communications:** We may communicate to you via newsletters, mailings or other means regarding treatment options, information on health-related benefits or services; to remind you that you have an appointment for medical care; or other community based initiatives or activities in which our facility is participating. If you are not interested in receiving these materials, please contact our Privacy Officer.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

1. **As required by law.** We may use and disclose health information to the following types of entities, including but not limited to:
 - Food and Drug Administration
 - Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
 - Correctional Institutions
 - Workers Compensation Agents
 - Organ and Tissue Donation Organizations

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- Military Command Authorities
 - Health Oversight Agencies
 - Funeral Directors, Coroners and Medical Directors
 - National Security and Intelligence Agencies
 - Protective Services for the President and Others
 - Authority that receives reports on abuse and neglect
2. Law Enforcement/Legal Proceedings: We may disclose health information for law-enforcement purposes as required by law or in response to a valid subpoena.
 3. State-Specific Requirements: Many states have requirements for reporting, including population-based activities relating to improving health or reducing health care costs.

Your Health Information Rights

Although your health record is the physical property of the Caselle Dental, LLC. that compiled it, you have the right to:

1. Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. We ask that you submit these requests in writing. Usually, this includes medical and billing records, but does not include psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. Requests for access to and copies of your medical information must be submitted to Caselle Dental, LLC. in writing. There is a charge of \$20.00 for records of one to five pages, and an additional charge of one dollar per page thereafter.
2. Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information by submitting a request in writing. You have the right to request an amendment for as long as we keep the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.
3. An Accounting of Disclosures: You have the right to request an accounting of our disclosures of medical information about you except for certain circumstances, including disclosures for treatment, payment, health care operations or where you specifically authorized a disclosure Caselle Dental, LLC. will provide the first accounting to you in any 12-month period without charge. The cost for subsequent requests for an accounting within the 12-month period will be \$20.00 for records of one to five pages, with an additional charge of one dollar per page thereafter. We ask that you submit these requests in writing.
4. Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure that you had. We ask that you submit these requests in writing.

Except under specific circumstances, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with

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emergency treatment or is required by law. We must agree to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the information pertains solely to a health care item or service for which we have been paid by you out-of-pocket, and in full.

5. **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you can ask that we use an alternative address for billing purposes. We ask that you submit these requests in writing.
6. **A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To exercise any of your rights, please obtain the required forms from the Privacy Officer and submit your request in writing.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us by calling 978-657-4550 and asking for the Privacy Officer or by contacting the Secretary of the Federal Department of Health and Human Services. All complaints must be also submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your permission and we are required to retain our records of the care that we provided to you.

Privacy Officer: Paul F. Caselle, DDS

Telephone Number: 978-657-4550