



Julie Dudevoir, DDS, MAGD
Prudence Taylor, DDS

CONWAY VILLAGE DENTAL

21A Poliquin Drive • Conway, NH 03818 603.447.6707

WELCOME TO OUR PRACTICE!

Thank you for choosing us to care for your dental needs. We want you to know that we are committed to providing you with the highest quality of care. It is important for you to understand that you may or may not have a dental cleaning at your new patient appointment. This will depend on how recently/frequently you have had dental care, and the health of your teeth and gums. We hope that your visit will be comfortable as well as helpful in achieving optimum oral health.

Our office is open Monday, Wednesday, Thursday and Friday 8:00 am – 5:00 pm, Tuesday, 8:30 am – 5:00 pm by appointment only. As a courtesy to our patients we confirm by telephone two business days in advance. Please see cancellation policy.

Payment is expected when services are rendered. For your convenience, we accept Visa, MasterCard, and Discover. If you have dental insurance, we will be happy to process your claims for you.

Enclosed are the forms for you to complete and return to the office. Patients generally find it easier to provide detailed information when they complete this form at home particularly when they need to list current medications and dosages.

OUR OFFICE POLICY REGARDING X-RAYS (RADIOGRAPHS)

Radiographs are an invaluable and essential diagnostic tool in our endeavor to provide the best possible dental care for you. The clinical exam, in conjunction with appropriate radiographs, helps us to “see the whole picture” so we can recommend the best treatment options for your situation. Our office cannot provide adequate or complete care to you without their use. We are, however, very sensitive to the real and perceived risks of exposure to dental radiation. For this reason, we attempt to expose our patients to the least number of radiographs possible while maintaining their optimum diagnostic value. The dental health of our patients varies so it would follow that the need for radiographs varies as well. Ours is an individualized approach.

The use of radiographs is a part of the accepted standard of care in the dental profession. It is the position of this office that to treat patients who refuse their use is unethical.

If you would like to discuss this issue with the doctor or if you are interested in learning more about dental radiation and risks of exposure, please feel free to ask.



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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 is in effect. This Notice takes effect (04/14/03), 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 reasonable 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, 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 \$0.25 for each page, \$25 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 14, 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.

Contact Officer: Deborah Eastman



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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.

{Please Print Name}

{Signature}

{Date}

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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).



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Please fill out these forms completely. We are here to assist you if needed.

Today's date _____ Birth Date _____
 Name _____ Preferred Name _____
 Mailing Address _____ City _____
 State _____ Zip Code _____ SSN _____

Dental Insurance Information – Please provide Insurance Card

Name of Insured _____ Birth Date _____
 Name of Employer _____ Subscriber ID# _____
 Employer Address _____ Insurance Company _____
 Insurance Company Address _____

Contact Information: Email: _____

Home: _____
 Mobile: _____
 Work: _____

Preferred way to be contacted:

Mail Phone Text Email

MARITAL STATUS:

Minor Single Married
 Divorced Widowed Separated

Person to contact in emergency:

Phone Number: _____

Hobbies or activities you enjoy: _____

Responsible Party (if not the same as above):

Name _____ Birth Date _____
 Address _____ City _____ State _____ Zip Code _____

How did you hear about us?: Newspaper Social Media Internet Other: _____

Word-of-Mouth (who may we thank for referring you?): _____

How will you pay for your dental visits: Cash Check Credit Card Care Credit

Dental History

Previous dentist _____ Date last there _____

How often do you visit the dentist? _____

Have you had any periodontal surgery or deep teeth cleanings? _____

Have you had any treatment with a dental specialist? _____ If yes, what type of specialist?
(examples: Orthodontist, Periodontist, Oral surgeon, Endodontist) _____

Do you have any dental implants? _____

Do you wear a bite guard to protect your teeth? _____ If yes, what type _____

Please circle the appropriate response:

- | | | | | | |
|--|---|---|---|---|---|
| 1) Do your gums bleed while brushing or flossing? | Y | N | 9) Do you have frequent headaches? | Y | N |
| 2) Are your teeth sensitive to hot or cold? | Y | N | 10) Do you clench or grind your teeth? | Y | N |
| 3) Are your teeth sensitive to sweet or sour? | Y | N | Daytime or nighttime? _____ | | |
| 4) Do you feel pain to any of your teeth? | Y | N | 11) Do you bite your lips or cheeks often? | Y | N |
| 5) Do you have any sores or lumps in your mouth? | Y | N | 12) Have you ever had any difficult extractions | | |
| 6) Do you have any sores on your head or neck? | Y | N | in the past? | Y | N |
| 7) Have you had any injuries to your head or neck? | Y | N | 13) Have you ever had prolonged bleeding | | |
| 8) Have you experienced any TMD symptoms such as: | | | following extractions | Y | N |
| Clicking or pain | Y | N | 14) Have you had any orthodontic work? | Y | N |
| Difficulty opening or closing | Y | N | 15) Have you had instructions on the correct | | |
| Difficulty chewing | Y | N | way to brush and floss? | Y | N |
| Ringing in ears or ear pain | Y | N | 16) Do you wear dentures or partials? | Y | N |
| Vertigo or plugged ears | Y | N | If yes, date received _____ | | |
| Blurred vision | Y | N | 17) Do you like your smile? | Y | N |

Medical History

Physician _____ **Office Phone** _____ **Date of last exam** _____

- | | | | | | |
|---|---|---|--|---|---|
| 1) Are you under medical treatment? | Y | N | 6) Are you allergic to or have you had any reactions | | |
| If yes, please explain further on page 3. | | | to the following: | | |
| 2) Have you been hospitalized for any surgical | | | Local Anesthetics | Y | N |
| treatment or serious illness within the past 5 years? | Y | N | Sedatives | Y | N |
| If yes, please list on page 3 | | | Penicillin | Y | N |
| 3) Do you use any of the following: | | | Aspirin | Y | N |
| Tobacco | Y | N | Codeine | Y | N |
| Alcohol | Y | N | Antibiotics | Y | N |
| Aspirin | Y | N | Latex | Y | N |
| Plavix | Y | N | Sulfa Drugs | Y | N |
| Coumadin | Y | N | General anesthesia | Y | N |
| Blood Thinners | Y | N | Barbiturates | Y | N |
| Bisphosphonate Drugs (i.e. Fosamax, etc.) | Y | N | Metals | Y | N |
| Controlled Substances | Y | N | 7) Do you wake up frequently at night? | Y | N |
| Cholesterol medication | Y | N | 8) Do you have frequent throat infections? | Y | N |
| 4) Have you been diagnosed with any learning or | | | 9) Have you been diagnosed with any condition | | |
| developmental delays? | Y | N | you feel we should know about? | Y | N |
| 5) Do you have a persistent cough | Y | N | 10) Do you have a pain management agreement | | |
| | | | with another doctor? | Y | N |

Women Only:

Are you pregnant or think you may be? Y N Are you nursing? Y N Are you taking oral contraceptives? Y N

Do you have or have you ever had any of the following?

Anemia	Y N	Emphysema/COPD	Y N	Radiation Therapy	Y N
Angina	Y N	Epilepsy/convulsions	Y N	Recent Weight Loss	Y N
AIDS or HIV	Y N	Fainting	Y N	Respiratory Problems	Y N
Anxiety	Y N	Frequently Tired	Y N	Rheumatic Fever	Y N
Arthritis	Y N	Glaucoma	Y N	Seizures	Y N
Asthma	Y N	Hay Fever	Y N	Seasonal Allergies	Y N
Bleeding Issues	Y N	Heart Attack	Y N	Sexually Transmitted Disease	Y N
Cardiac Pacemaker	Y N	Heart Disease	Y N	Sinus Pain	Y N
Cardiac Valve Replacement	Y N	Hepatitis/Jaundice	Y N	Stomach Troubles/Acid Reflux	Y N
Cancer	Y N	High Blood Pressure	Y N	Stroke	Y N
Chemotherapy	Y N	High Cholesterol	Y N	Swollen Ankles	Y N
Chest pain	Y N	Joint Replacement	Y N	Thyroid Problem	Y N
Chronic Sore Throat	Y N	Implants	Y N	Tuberculosis	Y N
Chronic Chest Pain	Y N	Kidney Disease	Y N	Other _____	
Congenital Heart Disease	Y N	Leukemia	Y N	Dr. Notes: _____	
Diabetes	Y N	Liver Disease	Y N	_____	
Drug Addiction	Y N	Low Blood Pressure	Y N	_____	
Easily Winded	Y N	Psychiatric Care	Y N	_____	

Please List: Medications, Vitamins, and Herbal Therapies:

Please List: Surgeries and Hospitalizations with dates: _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf and my dependents.

Please read the following regarding broken appointment fees and finance charges.

There will be a \$50.00 minimum charge for broken appointments and appointment cancellations without 24 business hour notice. If you know that you cannot keep an appointment, please call and notify us as soon as possible. If you have insurance, we will gladly process your claim. Your portion will be due on the day services are provided. Any balance 90 days past due will be assessed a finance charge of 1.8% a month.

Signature of patient (or parent/guardian) X _____ Date _____

Signature of Doctor X _____ Date _____



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AUTHORIZATION TO RELEASE DENTAL RECORDS

Patient's Name: _____ Date of Birth: _____

I request and authorize _____ to Release dental information of the patient above to:

Conway Village Dental
21A Poliquin Drive
Conway, New Hampshire 03818

Phone: (603) 447-6707

Fax: (603) 447-8376

Email: FrontDesk@ConwayVillageDental.com

This request and authorization applies to:

All Dental Records

Other: _____

Patient Signature _____ Date: _____

Date: _____
Parent/Legal Guardian/Representative (if a minor)

Last Prophylaxis: _____

BWX: _____

FMX/PANO: _____

Other: _____