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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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: _____

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

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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FINANCIAL POLICY

This form explains to all of our patients the billing process specific to our office -- much like a payment agreement for a credit card, or billing policies and procedures for utility companies. For the answers to any questions you have, please refer to our front desk staff-- they are here to help!

The primary goal of our dental practice is to provide the highest quality oral health care in the most gentle, efficient and enthusiastic manner. Since our practice is also a business with obligations that must be met, we ask that all patient that do not have dental insurance pay for their treatment in full on the day of each visit to our office unless prior arrangements have been made.

We will do our best to give you a rough estimate of your investment in your dental health for each upcoming visit, based on your individual treatment plan. You will be given a very close estimate of your next visit's total bill. Please bring cash, check or credit card at the time of treatment. With a proper diagnosis and a timely treatment plan, most estimates we provide are accurate.

Outstanding balances on your account are discouraged, and must be cleared before the next appointment for any account member or within 30 days of treatment, whichever comes first. Appointments for non-emergency treatment may need to be postponed pending payment of outstanding balances. Amount due and not paid in full within 60 days will be charged interest at a rate of 1.8% per month.

A returned check fee of $40.00 (subject to change as bank fees increase) will be added to your account for any returned check. Before we accept another payment by check, the $40.00 fee plus full payment for the check that did not clear must be paid in cash, or by VISA, MasterCard, or Discover.

Your dental appointments are scheduled carefully. Time, trained personnel and dental equipment are reserved for each procedure. Missed appointments add to the cost of dental care when reserved facilities are left waiting empty. We request 24 hour advance notice for rescheduling your appointment. Your account will be charged a broken appointment fee of $50.00 for any missed appointments without proper notification. We reserve the right to terminate professional treatment of any patient if multiple scheduled appointments are not kept.

Minor Patients. The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without exception. This office will not attempt to collect from a parent that is not present in the office at the visit.

You need to bring your insurance card, coverage booklet, and a completed and signed dental insurance claim form at your first visit, and at any time your insurance changes. You need to be aware that:

- We will always do our best to help you to maximize your benefits.
- Although we file claims for you as a courtesy, your dental insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract.

- Your treatment plan is individually tailored and based on your unique oral health needs. It is not based on your dental insurance benefits or lack of benefits.

- Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. Coverage issues can only be addressed by your employer or group plan administrator. We cannot act as a mediator with the carrier or your employer.

- As a courtesy to all of our insured patients, we will file your dental insurance claim immediately, and benefits are expected to be paid within 30 days. The filing of an insurance claim does not relieve you of timely payment on your account. You are responsible at the time of treatment for payment to us of any applicable deductible and for your coinsurance portion. You are responsible for any amounts your insurance company chooses not to pay, for whatever reason. Any amounts expected to be paid by your insurance company, but not cleared by them within 60 days become your responsibility and, if not paid in a timely fashion, will begin to accumulate interest at the rate of 1.8% per month. *Please feel free to contact your insurance company regarding unpaid benefits.*

I understand and accept the financial and the dental insurance policies listed above and have had any and all questions answered to my satisfaction. I agree to pay for all treatment in a timely fashion as described so as to avoid any additional fees. I hereby authorize my insurance benefits to be paid directly to Conway Village Dental I realize that I am responsible to pay for any deductible amount(s), my co-insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

PRINT PATIENT NAME_____

SIGNATURE (PARENT/GUARDIAN IF DEPENDENT) _____

DATE_____

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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
2) Are your teeth sensitive to hot or cold? Y N
3) Are your teeth sensitive to sweet or sour? Y N
4) Do you feel pain to any of your teeth? Y N
5) Do you have any sores or lumps in your mouth? Y N
6) Do you have any sores on your head or neck? Y N
7) Have you had any injuries to your head or neck? Y N
8) Have you experienced any TMD symptoms such as:
   - Clicking or pain Y N
   - Difficulty opening or closing Y N
   - Difficulty chewing Y N
   - Ringing in ears or ear pain Y N
   - Vertigo or plugged ears Y N
   - Blurred vision Y N
9) Do you have frequent headaches? Y N
10) Do you clench or grind your teeth? Y N
    Daytime or nighttime?_____
11) Do you bite your lips or cheeks often? Y N
12) Have you ever had any difficult extractions in the past? Y N
13) Have you ever had prolonged bleeding following extractions Y N
14) Have you had any orthodontic work? Y N
15) Have you had instructions on the correct way to brush and floss? Y N
16) Do you wear dentures or partials? Y N
    If yes, date received_____
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
If yes, please explain further on page 3.
2) Have you been hospitalized for any surgical treatment or serious illness within the past 5 years? Y N
If yes, please list on page 3
3) Do you use any of the following:
   - Tobacco Y N
   - Alcohol Y N
   - Aspirin Y N
   - Plavix Y N
   - Coumadin Y N
   - Blood Thinners Y N
   - Bisphosphonate Drugs (i.e. Fosamax, etc.) Y N
   - Controlled Substances Y N
   - Cholesterol medication Y N
4) Have you been diagnosed with any learning or developmental delays? Y N
5) Do you have a persistent cough Y N
6) Are you allergic to or have you had any reactions to the following:
   - Local Anesthetics Y N
   - Sedatives Y N
   - Penicillin Y N
   - Aspirin Y N
   - Codeine Y N
   - Antibiotics Y N
   - Latex Y N
   - Sulfa Drugs Y N
   - General anesthesia Y N
   - Barbiturates Y N
   - Metals Y N
7) Do you wake up frequently at night? Y N
8) Do you have frequent throat infections? Y N
9) Have you been diagnosed with any condition you feel we should know about? Y N
10) Do you have a pain management agreement with another doctor? Y N

Do you **PREMEDICATE** with antibiotics? Y N **If YES – Amoxicillin Keflex Clindamycin**

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_____