Shanti Dental, PC

222 Milliken Blvd
Fall River, MA 02721
508-672-7525

GENERAL CONSENT

Please read this form carefully. Should you have any questions, our staff will be happy to help you.

1.) I hereby authorize and direct the dentist and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.

2.) I understand x-rays, photographs, models of the mouth, and/or other diagnostic aids used for an accurate diagnosis and treatment planning are the property of the doctors but copies of certain aids are available upon request for a fee.

3.) In general terms, the dental procedures can include but not limited to:

A. Comprehensive oral examination, radiographs, cleaning of the teeth, and topical fluoride application.
B. Application of resin “sealants” to the grooves of the teeth.
C. Treatment of diseased, or injured teeth with dental restorations (fillings).
D. Treatment of diseased or injured oral tissue secondary to traumatic injuries and/or accidents and/or infections.

4.) I understand that the doctor is not responsible for previous dental treatment performed in other offices. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service.

5.) I certify that if I, and/or my dependents have insurance coverage I assign directly to the dentist all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

6.) I have answered all of the questions about me or my dependent’s medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all medical conditions, including allergies. I also understand if my dependent or I ever have any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

_____ _____

SIGNATURE DATE

_____ _____

PATIENT NAME DATE OF BIRTH

_____ _____

PARENT/GUARDIAN NAME IF PATIENT IS MINOR RELATIONSHIP TO PATIENT

Welcome to Shanti Dental, PC

Nothing needs to stand between you and the smile of your dreams.

Patient Registration Form

Date:_____

PATIENT'S NAME: _____**PREFERRED NAME**: _____
FIRST MIDDLE LAST JR SR

PATIENT'S SOCIAL SECURITY #_____ DATE OF BIRTH: _____ M or F

PATIENT'S HOME ADDRESS_____ City _____ State _____ Zip _____

PATIENT'S MAILING ADDRESS _____ City _____ State _____ Zip _____

HOME PHONE#_____ MOBILE#_____

EMPLOYER_____ WORK#_____

E-MAIL ADDRESS _____

PREVIOUS DENTIST _____DENTIST PHONE#_____ DATE OF LAST VISIT_____

PHARMACY_____ ADDRESS_____ PHONE _____

IF MORE THAN ONE MEMBER OF YOUR FAMILY IS A PATIENT WITH OUR OFFICE, PLEASE PROVIDE THE NAME OF THE PRIMARY ACCOUNT HOLDER _____

PRIMARY DENTAL INSURANCE NAME _____

SUBSCRIBER NAME _____ DATE OF BIRTH _____

SUBSCRIBER'S EMPLOYER _____ SUBSCRIBER ID OR SS NUMBER _____

PLEASE CIRCLE **PATIENT'S** RELATIONSHIP TO SUBSCRIBER: **SELF SPOUSE DEPENDENT CHILD OTHER_____**

WHO MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE _____

DENTAL HISTORY

ARE ANY OF YOUR TEETH SENSITIVE TO:

HOT OR COLD	YES NO
SWEETS	YES NO
BITING OR CHEWING	YES NO

HAVE YOU NOTICED:

BAD TASTE OR ODOR	YES NO
FREQUENT COLD SORES	YES NO
BLEEDING OR PAINFUL GUMS	YES NO
LOOSE TEETH/CHANGE IN BITE	YES NO
FOOD CAUGHT BETWEEN TEETH	YES NO

DO YOU:

CLENCH/GRIND YOUR TEETH	YES NO
BITE CHEEKS OR LIPS FREQ.	YES NO
HOLD OBJECTS WITH TEETH	YES NO
SNORE	YES NO
SMOKE/CHEW TOBACCO	YES NO

HAVE YOU EVER HAD:

ORTHODONTIC TREATMENT (BRACES)	YES NO
ORAL SURGERY	YES NO
PERIODONTAL TREATMENT (GUM TREATMENT)	YES NO
MOUTHGUARD	YES NO

HAVE YOU EXPERIENCED:

CLICKING OR POPPING IN JAW	YES NO
PAIN IN JAW/EAR/SIDE OF FACE	YES NO
DIFFICULTY OPENING/CLOSING MOUTH	YES NO
HEAD/NECK/SHOULDER ACHES	YES NO
SORE MUSCLES	YES NO
ARE YOU SATISFIED WITH YOUR TEETH'S APPEARANCE:	YES NO
WOULD YOU LIKE TO KEEP ALL OF YOUR TEETH?	YES NO
DO YOU FEEL NERVOUS ABOUT DENTAL TREATMENT?	YES NO
BIGGEST CONCERN _____	
HAVE YOU HAD AN UPSETTING DENTAL EXPERIENCE?	YES NO
PLEASE EXPLAIN_____	

HAVE YOU EVER BEEN TOLD TO TAKE A PRE-MEDICATION PRIOR TO DENTAL TREATMENT? YES NO

PLEASE LIST ANYTHING ELSE YOU WOULD LIKE US TO KNOW REGARDING YOUR DENTAL TREATMENT:

_____

PLEASE COMPLETE YOUR HEALTH HISTORY LOCATED ON THE BACK OF THIS PAGE!

GENERAL MEDICAL / HEALTH HISTORY **NAME:**_____ **DOB:**_____

PRIMARY CARE PHYSICIAN NAME_____ CITY_____PHONE_____

EMERGENCY CONTACT NAME_____ **PHONE#**_____

HAVE YOU HAD ANY MEDICAL CARE IN THE LAST TWO YEARS?_____ YES NO

DESCRIBE:_____

HAVE YOU TAKEN ANY MEDICATION OR DRUGS DURING THE PAST TWO YEARS?_____ YES NO

ARE YOU CURRENTLY TAKING ANY MEDICATIONS(PRESCRIPTION OR OVER THE COUNTER), DRUGS, ASPIRIN ETC?___ YES NO

PLEASE LIST:_____

HAVE YOU TAKEN ANY OF THE FOLLOWING MEDICATIONS FOR WEIGHT LOSS_____ YES NO

CIRCLE: FEN-PHEN PONDIMEN REDUX OTHER

IF SO, DID YOU HAVE A MEDICAL EXAM FOR HEART ISSUES? YES NO

HAVE YOU EVER TAKEN ANY BONE LOSS PREVENTION DRUGS (FOSAMAX, ACTONEL, BONIVA, ETC)_____ YES NO

ARE YOU AWARE OF HAVING AN ALLERGIC OR ADVERSE REACTION TO ANY SUBSTANCE OR MEDICATION_____ YES NO

PLEASE LIST :_____

HAVE YOU BEEN A PATIENT IN THE HOSPITAL DURING THE PAST FIVE YEARS_____ YES NO

PLEASE DESCRIBE:_____

DO YOU HAVE, OR HAVE YOU HAD IN THE PAST, ANY OF THE FOLLOWING:

HEART SURGERY, DISEASE, OR HEART ATTACK	YES NO	ORGAN TRANSPLANTS_____	YES NO
CHEST PAINS_____	YES NO	DIABETES - **HbA1c#**:_____	YES NO
CONGENITAL HEART DISEASE_____	YES NO	THYROID PROBLEMS_____	YES NO
HEART MURMUR_____	YES NO	GLAUCOMA_____	YES NO
HIGH /LOW BLOOD PRESS **(PLEASE CIRCLE**)_	YES NO	CONTACT LENSES_____	YES NO
MITRAL VALVE PROLAPSE_____	YES NO	EMPHYSEMA_____	YES NO
ARTIFICIAL HEART VALVE OR PACEMAKER____	YES NO	CHRONIC COUGH_____	YES NO
RHEUMATIC FEVER_____	YES NO	TUBERCULOSIS_____	YES NO
ARTHRITIS/RHEUMATISM_____	YES NO	ASTHMA_____	YES NO
CORTISONE MEDICATION_____	YES NO	HAY FEVER, ALLERGIES, OR HIVES_____	YES NO
SWOLLEN ANKLES_____	YES NO	LATEX ALLERGY OR SENSITIVITY_____	YES NO
CANCER OR TUMORS_____	YES NO	SINUS TROUBLE_____	YES NO
RADIATION THERAPY_____	YES NO	SPECIAL OR RESTRICTED DIET_____	YES NO
CHEMOTHERAPY_____	YES NO	ARTIFICIAL JOINTS (KNEE, HIP, ETC)_____	YES NO
KIDNEY TROUBLE_____	YES NO	ULCERS OR ACID REFLUX (**PLEASE CIRCLE**)_____	YES NO
COLD SORES OR FEVER BLISTERS_____	YES NO	HEPATITIS A, B, C (**PLEASE CIRCLE**)_____	YES NO
HEMOPHILIA_____	YES NO	BLOOD TRANSFUSION_____ _	YES NO
BRUISE EASILY_____	YES NO	SICKLE CELL DISEASE_____	YES NO
NEUROLOGICAL DISORDERS_____	YES NO	FAINTING OR DIZZY SPELLS_____	YES NO
LIVER DISEASE OR JAUNDICE_____	YES NO	EPILEPSY OR SEIZURES_____	YES NO
VENEREAL DISEASE/STD_____	YES NO	AIDS/HIV POSITIVE_____	YES NO
STROKE_____	YES NO	NERVOUS OR ANXIOUS_____	YES NO
ANEMIA_____	YES NO	PSYCHIATRIC OR PSYCHOLOGICAL CARE_____	YES NO
EATING DISORDER-SPECIFY:_____	YES NO	ALCOHOL OR SUBSTANCE ABUSE(**PLEASE CIRCLE**)	YES NO

HAVE YOU GAINED OR LOST 10 (PLEASE CIRCLE) OR MORE POUNDS IN THE LAST YEAR? YES NO

DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE? **YES NO**

PLEASE LIST:_____

WOMEN ONLY:

ARE YOU PREGNANT OR THINK YOU COULD BE?	YES NO	ARE YOU NURSING?_____	YES NO
HOW MANY WEEKS?_____		ARE YOU USING BIRTH CONTROL?_____	YES NO

I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER. I HAVE ANSWERED ALL QUESTIONS TO THE BEST OF MY KNOWLEDGE. SHOULD FURTHER INFORMATION BE NEEDED, YOU HAVE MY PERMISSION TO ASK THE RESPECTIVE HEALTH CARE PROVIDER OR AGENCY, WHO MAY RELEASE SUCH INFORMATION TO YOU. I WILL NOTIFY THE DOCTOR OF ANY CHANGE IN MY HEALTH OR MEDICATION.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

DOCTOR/HYGIENIST SIGNATURE: _____ DATE: _____

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OPTIONAL CONSENT TO DISCLOSE HEALTHCARE INFORMATION TO ANOTHER PERSON(S)

PATIENT GIVING CONSENT:

Name:_____ DOB:_____

PERSONS INVOLVED IN CARE:

List individuals who you would like involved in your dental care. By writing their names on this form, you consent to the release of your dental information to them (for example, if you want us to be able to discuss dental information/financial information with your spouse/child/parent, you must write their names below. This includes but does not limit to discussing fillings, crowns, bills, and payments with them).

_____ _____

_____ _____

PURPOSE OF CONSENT:

By signing this form, you consent to us discussing your protected health information to carry out treatment, payment activities, and healthcare operations with the above named.

You may revoke this Consent at any time by giving us written notice of your revocation submitted to this office. Please understand that revocation of this Consent will NOT affect any action we took in reliance with this Consent before we received your revocation.

CONSENT:

I have had full opportunity to read and consider the contents of this consent form. I understand, by signing this Consent form, I am giving my consent to your disclosure of my protected health information to those listed above.

SIGNATURE: _____ **DATE:**_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient's name:_____ DOB:_____

If this consent is signed by a personal representative on behalf of the patient (child), complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notices accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions, at any time by contacting:

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent and Acknowledgement form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations and I am acknowledging receipt of the copy of the Notice of Privacy Practices.

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Office Staff: We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining acknowledgment
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify):_____

REVOCATION OF CONSENT

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Contact Person listed above. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

Signature: _____ Date: _____

You are entitled to a copy of this consent after you sign it. If you request a copy, the original will be in your patient chart.

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 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 02/10/10, 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 this 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 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 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 professions, evaluation 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 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 the 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 With Care: We may use and disclose your 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 disclose your health information or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgement 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.

Requires By Law: We may use and disclose your health information when we are required by law to do so.

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 and 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 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 may 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 may charge you for each page, and 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 may 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 fee. Contact us using the information listen 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 six years, but not before April 14, 2003. If you request this accounting more than once in a twelve month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You may have the right to request that we place additional restrictions on our use and disclose 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 website or by electronic mail, you are entitled to receive this Notice in paper form.

Questions and Complaints:
If you want more information about privacy practices or have questions or concerns, please contact us.

If you are concerned that we 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 locations, you may complain to us using the contact information listen at the end of this Notice. You 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.

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ATTN: Complaints Officer
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