DANVERS
Dental Care

Welcome!

Dr. Paul DeFeo, DMD
Dr. Paul Corrado, DDS
Dr. Michael Costello, DMD

We would like to take this opportunity to welcome you to our dental practice. Our practice has grown almost exclusively by our patients' kind and generous referrals. We take pride in offering our community the highest quality of dentistry while providing our patients with a comfortable, friendly, and caring environment.

Let us explain a little about our office philosophy and goals. We believe in the concept of preventative care, regular check-ups, and education when it comes to optimal dental health. As a family practice we care for patients of all ages, from infants to senior citizens.

Our patients can expect from us:

- a high degree of professional skill and ability
- a dedication to your oral health care
- a minimization of costly reconstructive work through timely and proper preventative care
- the highest effort to make your visit as relaxing and comfortable as possible
- the right treatment at the right time
- fees that are fair and just for the services provided.

In return, we expect from our patients:

- commitment in making and keeping appointments. (we appreciate 24 hours notice to change an appointment)
- a conscientious effort toward good oral hygiene
- continuing recall hygiene visits to maintain optimal oral health
- a firm arrangement and commitment for payment of services at time of treatment
- following through with recommendations of the doctor

We believe that open and honest communication is the best basis for any relationship. If at any time you have a question, are concerned, or unhappy with your treatment, please discuss it with us promptly and openly. Misunderstanding and/or lack of communication are the only obstacles to our continued friendship and professional relationship.

We are looking forward to meeting you soon.

40 Poplar Street • Danvers, MA 01923
Phone: (978) 774-8181 Fax: (978) 774-7979
www.danversdentalcare.com

DANVERS Dental Care

Patient REGISTRATION

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

E-Mail _____

Address _____

City _____

State _____

Zip _____

Sex ❑ M ❑ F Age _____ Birthdate _____

❑ Married ❑ Widowed ❑ Single ❑ Minor
❑ Separated ❑ Divorced ❑ Partners for ___ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

ID # _____ Group # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____

Birthdate _____ ID# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company

Danvers Dental Care, P.C., all insurance benefits, if any, otherwise payable to me 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.

The above-named practice may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

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

Spouse's work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 DENTAL HISTORY

Reason for today"s visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Please answer "yes" or "no" if you have had:

Bad breath	❑ Yes	❑ No
Bleeding Gums	❑ Yes	❑ No
Blisters on Lips or Mouth	❑ Yes	❑ No
Burning Sensation on Tongue	❑ Yes	❑ No
Chew on one side of mouth	❑ Yes	❑ No
Cigarette, pipe, cigar smoking	❑ Yes	❑ No
Clicking or popping jaw	❑ Yes	❑ No
Dry mouth	❑ Yes	❑ No
Food collection between teeth	❑ Yes	❑ No
Foreign objects	❑ Yes	❑ No
Grinding Teeth	❑ Yes	❑ No
Gums swollen or tender	❑ Yes	❑ No
Jaw pain or tiredness	❑ Yes	❑ No
Lip or cheek biting	❑ Yes	❑ No
Loose teeth or broken fillings	❑ Yes	❑ No
Mouth breathing	❑ Yes	❑ No
Mouth pain, brushing	❑ Yes	❑ No
Orthodontic Treatment	❑ Yes	❑ No
Pain around ear	❑ Yes	❑ No
Periodontal treatment	❑ Yes	❑ No
Sensitivity to cold	❑ Yes	❑ No
Sensitivity to heat	❑ Yes	❑ No
Sensitivity to sweets	❑ Yes	❑ No
Sensitivity when biting	❑ Yes	❑ No
Sores or growths in your mouth	❑ Yes	❑ No

How often do you floss? _____

How often do you brush? _____

PLEASE FILL OUT BOTH SIDES OF THIS FORM

5 HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine, Pondimin (fenfluramine) and Redux (dexfenfluramine). ❑ Yes ❑ No

Place a mark on "yes" or "no" if you have had any of the following:

AIDS/HIV	❑ Yes	❑ No	Epilepsy	❑ Yes	❑ No	Respiratory Disease	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Fainting or dizziness	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No
Arthritis, Rheumatism	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No	Scarlet Fever	❑ Yes	❑ No
Artificial Heart Valves	❑ Yes	❑ No	Headaches	❑ Yes	❑ No	Shortness of Breath	❑ Yes	❑ No
Artificial Joints	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No	Sinus Trouble	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Heart Problems	❑ Yes	❑ No	Skin Rash	❑ Yes	❑ No
Back Problems	❑ Yes	❑ No	Hepatitis Type _____	❑ Yes	❑ No	Special Diet	❑ Yes	❑ No
Bleeding abnormally, with extractions or surgery	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
			High Blood Pressure	❑ Yes	❑ No	Swollen Feet or Ankles	❑ Yes	❑ No
Blood Disease	❑ Yes	❑ No	Jaundice	❑ Yes	❑ No	Swollen Neck Glands	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Jaw Pain	❑ Yes	❑ No	Thyroid Problems	❑ Yes	❑ No
Chemical Dependency	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No	Tonsilitis	❑ Yes	❑ No
Chemotherapy	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Circulatory Problems	❑ Yes	❑ No	Low Blood Pressure	❑ Yes	❑ No	Tumor or growth on head or neck	❑ Yes	❑ No
Congenital Heart Lesions	❑ Yes	❑ No	Mitral Valve Prolapse	❑ Yes	❑ No			
Cortisone Treatments	❑ Yes	❑ No	Nervous Problems	❑ Yes	❑ No	Ulcer	❑ Yes	❑ No
Cough, persistent or bloody	❑ Yes	❑ No	Pacemaker	❑ Yes	❑ No	Venereal Disease	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Psychiatric Care	❑ Yes	❑ No	Weight loss, unexplained	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No	Radiation Treatment	❑ Yes	❑ No			

Do you wear contact lenses? ❑ Yes ❑ No

Women:

Are you pregnant? ❑ Yes ❑ No If yes, list due date_____ Are you nursing? ❑ Yes ❑ No

Taking birth control pills? ❑ Yes ❑ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____)_____

ALLERGIES

❑ Asprin ❑ Local Anesthetic

❑ Barbiturates (sleeping pills) ❑ Penicillin

❑ Codeine ❑ Sulfa

❑ Iodine ❑ Other_____

❑ Latex _____

6 UPDATES (To be filled in at future appointments)

Has there been any changes in your health since your last dental appointment? ❑ Yes ❑ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature_____ Date _____

Has there been any changes in your health since your last dental appointment? ❑ Yes ❑ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature_____ Date _____

PLEASE FILL OUT BOTH SIDES OF THIS FORM

Understanding YOUR INSURANCE

Understanding your insurance coverage can be very challenging. Our goal is to assist you in maximizing your benefits. Benefits vary from plan to plan and employer to employer. It is your responsibility to become familiar with your policy's exclusions, deductibles, maximums and required co-payments. Please be aware that dental insurance differs from medical insurance in that all co-pays vary depending on procedures, surfaces, materials used, etc. Your insurance policy is a contract between you and your insurance company and we are not party to that contract. Our fees are your responsibility whether or not the insurance company pays your claim.

Our courtesy service to you includes:

1. Electronically filing your insurance claims within 24 hours of your visit and requesting payment of your benefit to our office.
2. Researching your dental insurance plan to advise you of your benefits
3. Furnishing your plan with all the necessary documentation required for approval of extensive treatment.
4. Following the American Dental Association guidelines for coding procedures in accordance with the insurance company.

Our expectations of you as a policy owner:

1. Estimated co-payment at time of service.
2. Understanding that the dental insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Realizing that some dental insurance policies restrict payment for some services, use restricted fee schedules (usual and customary rates) and exclude some procedures based on prior conditions of length of time on plan. All restrictions are based on the premium paid for insurance, not our fees or recommended treatment.
4. Paying any and all insurance claims that have not been paid within 60 days of submission.
5. Keeping our office updated of any changes to your insurance or employment.

Thank you for your cooperation with your dental insurance coverage.
Please sign the space below and have your insurance card ready for us to copy for our file.

I hereby authorize Danvers Dental Care to release my insurance company information required during my dental care. I hereby authorize benefits to be paid directly to Danvers Dental Care, P.C. I understand that I am responsible for any unpaid balance.

PATIENT SIGNATURE (OR GUARDIAN IF UNDER 18)

Danvers Dental Care • 40 Poplar Street • Danvers, MA 01923 • Phone: (978) 774-8181 • Fax: (978) 774-7979
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Polcies Regarding
FINANCIAL ARRANGEMENTS

INSURED PATIENTS
Please present your dental insurance card at the front desk. If your insurance changes, please notify us as soon as possible. Your deductible and estimated co-payment is due at the time of service. As a service to our patients, our office will submit your claim to your insurance company. You are responsible for all fees at time of service that insurance does not cover or denies for any reason.

NON-INSURANCE / COBRA / WORKMAN'S COMPENSATION PATIENTS
Payment is due at time of service.

DIVORCE:
In cases of divorced parents, the parent that brings the child is responsible for payment.

PAYMENT OPTIONS:
We accept cash, personal checks, credit cards (VISA, MasterCard, Discover and American Express), as well as CareCredit (a healthcare financing option).

RETURNED CHECKS/COLLECTIONS:
We will assess your account $25.00 for any check returned to us by the bank. The patient also agrees to pay legal and collection fees should their account be delinquent and have to be turn over to our collection agency.

MISSED OR LATE APPOINTMENTS:
So that we may continue to offer convenient appointment times to all of our patients, we ask that if you need to change an appointment, you please give us 24 hours advance notice. A $25.00 fee will be added to your account if you cancel your appointment without giving our office 24 hours advance notice. Also, please understand that if a patient is 15 minutes late for an appointment, it may be necessary to modify or reschedule the appointment.

I have read the above Patient Agreement and I fully understand my responsibilities as a patient.

_____

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Your Health Information Rights

Although your health record is the physical property of the practice that compiled it, you have the right to:

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 your request in writing. Usually, this includes medical and billing records, but does not include psychotherapy notes or information compiled in reasonable anticipation of , or for uses 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 Danvers Dental Care, P.C. in writing. The cost charged by the practice for copying releases of personal health information may be up to the maximum prescribed by governing law.

Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask 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.

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. Danvers Dental Care, P.C., will provide the first accounting to you in any 12 month period without charge, upon your written request. The cost for subsequent requests for an accounting within the 12 month period will be up to the maximum prescribed by governing law.

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.

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 emergency treatment.

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.

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 practice and submit your request in writing to the practice's privacy officer indicated below.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us by calling (978)774-8181 and asking for the Privacy Officer or by contacting the Secretary of the Federal Department of Health and Human Services by calling 1-800-368-1019, or by contacting the Office of Civil Rights regional office. All complaints must also be submitted in writing within 180 days of when you knew that the act or omission complained of occurred. 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: Lynne Scanzillo
Telephone Number: (978) 774-8181

Your Privacy

HIPAA

Health Insurance Portability and Accountability Act of 1996

DANVERS Dental Care

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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 your care generated by your health care provider.

Our Responsibilities

Danvers Dental Care, PC is required by law to maintain the privacy of your health information and to provide you with a description of your legal duties and privacy practices regarding your health information. The current notice will be posted at the main reception desk. The notice will include the effective date. In addition, we will make our best effort to provide you with a copy of this notice that we request you acknowledge with your signature.

We are required by law to abide by the terms of this notice and notify you if we make any 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 posted at the main reception desk. You may also request 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:

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 care provider to whom you have been referred so as to ensure that the doctor has appropriate information regarding your previous treatment and diagnosis.

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.

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 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 care provider 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.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include software support, dental laboratories, billing and collections, and practice management consulting. 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.

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 an emergency situation), then your clinician may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the information relevant to your health care will be disclosed.

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 care or who helps 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.

Future Communications: We may communicate to you via newsletters, mailings, or other means regarding treatment options, information on health-related benefits and services; to remind you that you have an appointment for medical care; or other community base initiatives in which our facility is participating. If you are not interested in receiving such 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.

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
- 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

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes, as required by law or in response to a valid subpoena or court order.

State-Specific Requirements: Many states have requirements for reporting which may include population-based activities relating to improving health or reducing health care costs, cancer registries, birth defect registries, and others.

Privacy Policy

YOUR RIGHTS AS A PATIENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

DANVERS Dental Care

Dr. Paul DeFeo, DMD
Dr. Paul Corrado, DDS
Dr. Michael Costello, DMD

You may refuse to sign this acknowledgement.

I have received a copy of this office's
Notice of Privacy Practices

PRINT NAME

SIGNATURE

DATE

OFFICE USE ONLY:
We attemped to obtain written acknowledgement of Receipt of our Notice of Privacy Practices, but could not because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (please specify)_____