South Berwick Dental

PATIENT Information:

Name ____
First Last MI Preferred Name

Address ____
Street

City State Zip

Phone ____________ ____________ ____________
Cell Home Work

E-mail ____

Primary Care Provider ____________________________ **Tel #** ______________________________

How would you prefer to receive appointment reminders? Text E-mail Phone (Please circle)

If you are unavailable, may we leave a message? Y / N (Please circle)

PERSONAL

____________ ____________ ____________
Date of Birth Social Security Number Marital Status (S M W D Other)

____________ ____________ ____________
Occupation Employer Preferred Pharmacy

DENTAL

Who can we thank for referring you to our office? ______________________________

When and where was your last dental exam? ______________________________

How often do you brush your teeth? ____________ Floss? ____________

Do you grind or clench your teeth? Y / N / Not sure Do you have any jaw pain or clicking? Y / N

Have you had orthodontic treatment? Y / N Are you interested in straightening your teeth? Y / N

Have you ever whitened your teeth? Y / N Would you like whiter teeth? Y / N

Are you having any pain or areas of concern that you would like the dentist to evaluate? Y / N

Are you happy with your smile?   Y / N
If not, what don't you like?

____

Patient/Guardian Signature ____ **Date** _________________

South Berwick Dental

PRIMARY INSURANCE INFORMATION

Please e-mail a copy of the front and back of your insurance card

office@southberwickdental.net

Primary Insurance Information

Patient Name: ________________________________Date: ________________________

Name of Insured:________________________________Relationship to Patient: Self Spouse Child Other

Insured SSN: ________________________________Insured Date of Birth: ________________________

Company Name: ________________________________

Ins. Company: ________________________________

Address: ________________________________

City, State, Zip: ________________________________

Phone: ________________________________

ID#: ________________________________

Group#: ________________________________

Group Name: ________________________________

- We Participate with most Delta Dental Insurance please check with your group plan to make sure we are in network with your plan.

Assignment of Benefits

The undersigned patient, in requesting examination and/or treatment, authorizes the release of all information (including x-rays) relating to that examination or treatment to health service plans and insurance companies.

The undersigned patient also authorizes the release of such information to any peer review committee or state and local dental associations which may request it.

I hereby authorize payment directly to South Berwick Dental for group insurance benefits otherwise payable to me, but not to exceed the actual charges for the covered services. I understand that insurance companies do not guarantee payment in advance therefore I am financially responsible for any charges not covered by the group insurance benefits and that payment is due at the time of service.

Patient / Resp Party Signature:____ Date: __________________

South Berwick Dental

SECONDARY INSURANCE INFORMATION

Please e-mail a copy of the front and back of your insurance card

office@southberwickdental.net

Primary Insurance Information

Patient Name: ______________________________Date: _______________________

Name of Insured:________________________________Relationship to Patient: Self Spouse Child Other

Insured SSN: ________________________________Insured Date of Birth: ________________________

Company Name: ________________________________

Ins. Company: ________________________________

Address: ________________________________

City, State, Zip: _________________________________

Phone: ________________________________

ID#: ________________________________

Group#: ________________________________

Group Name: ________________________________

- We Participate with most Delta Dental Insurance please check with your group plan to make sure we are in network with your plan.

Assignment of Benefits

The undersigned patient, in requesting examination and/or treatment, authorizes the release of all information (including x-rays) relating to that examination or treatment to health service plans and insurance companies.

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I hereby authorize payment directly to South Berwick Dental for group insurance benefits otherwise payable to me, but not to exceed the actual charges for the covered services. I understand that insurance companies do not guarantee payment in advance therefore I am financially responsible for any charges not covered by the group insurance benefits and that payment is due at the time of service.

Patient / Resp Party Signature:_____________________________________ Date: _________________

Insurance Question and Answer page

Q: Why doesn’t my insurance cover all the costs for my dental treatment?

A: Dental insurance isn’t really insurance (a payment to cover the cost of a loss) at all. It is actually a money benefit typically provided by an employer to help their employees pay for routine dental treatment. The employer usually buys a plan based on the amount of the benefit and how much the premium costs per month. Most benefit plans are only designed to cover a portion of the total cost.

Q: But my plan says that my exams and certain other procedures are covered 100%

A: That 100% is usually what the insurance carrier allows as payment toward the procedure, not what your dentist or any other dentist in your area may actually charge. For example, say your dentist charges $80 for an examination (not counting x-rays). Your carrier may allow $60 as the 100% payment for that examination, leaving $20 for you to pay.

Q: If my plan does not really cover any procedures at 100% why does it say it will?

A: Benefit plan booklets are often difficult to understand. If any part of your plan is not clear to you or if you think something is wrong concerning what your plan covers, you should contact your Employee Benefits Coordinator or the Human Resource department where you work.

Q: What should I do if my insurance doesn’t pay for treatment I think should be covered?

A: Because your insurance coverage is between you, your employer, and the insurance carrier, your dentist does not have the power to make your plan pay. If your insurance doesn’t pay, you are responsible for the total cost of treatment. Sometimes a plan may pay if patients send in claims for themselves. The Employee Benefits Coordinator at your place of business also may be able to help. Consumers (patients) may also lodge complaints with the State Insurance Commission.
*Should you have further questions, we can offer you a brochure please ask at the front desk.

Record Release Form

_______________________________________ hereby authorize
(patient's printed name)

____
(former dentist's name)

To provide South Berwick Dental with copies of my dental records with respect to any dental care and treatment that I have received.

I understand that the specific type of information to be disclosed includes a detailed report of examinations, treatment provided, x-rays, and all other records which pertain to me.

This consent is effective until such date as I can cancel this consent. I understand that the information obtained as a result of this consent may be used after the cancellation date.

As applicable, please send all records for the following persons for whom I am either the parent, guardian or POA.

Child Name:_____________________________Date of Birth: _______
Child Name:_____________________________Date of Birth: _______
Child Name:_____________________________Date of Birth: _______
Child Name:_____________________________Date of Birth: _______

Signed,____________________________________
(patient)

Signed,____________________________________
(*patient, parent, legal guardian, or POA if patient is unable to sign for themselves)*

Printed name________________________________
(patient, parent, legal guardian, or POA)

Date__________________

Please mail or fax all records to:
South Berwick Dental
14 Highland Ave
So. Berwick, ME 03908
Tel. : (207)-384-2176
Fax : (207)-384-1981
Email : office@southberwickdental.net

South Berwick Dental

FINANCIAL POLICY

It is our primary goal to provide you with the best dental care. We know that sometimes the cost of treatment can prevent patients from receiving the treatment they want or need. Our team is here to help you navigate these financial barriers. We will make sure that you understand the fees associated with treatment, we will help you maximize your insurance benefits and we can help you with financing if/when needed. However, ultimately you are responsible for any fees incurred as clarified below.

We accept the following forms of payment: **Cash, Check, Major Credit Card, or CareCredit**

For Patients Without Dental Insurance:

Payment in full is due at the time service are rendered.

Although we do not offer in-house payment plans, we do offer third-party financing through CareCredit and we are more than happy to help you apply if desired.

For Patients With Dental Insurance:

In order to better assist you, please be sure to provide us with all of your insurance information. Also, please be sure to notify our office with any changes to your insurance coverage.

As a courtesy to our patients, we are happy to help you submit your dental claims to your primary insurance company. We will also **estimate** coverage at the time of your visit to determine any portion that will be due at the time services are rendered. This can be a deductible, co-pay or non-covered service.

Any portion left unpaid by insurance will be billed to you.

If there is a problem with your insurance claim or payment, we suggest that you contact your insurance carrier directly. Although we are always available to assist, the contract is between the insurance company and the insured.

*** Please note that all minors must be accompanied by a legal guardian**

I have read and agreed to the above policy,

Patient:________________________________Date:_______________

OR

Guardian:______________________________Date: _______________

South Berwick Dental

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.

We are required by 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 03/01/2021, 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 dentist, 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. By state law, your authorization is valid for 90 days.

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 you 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 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, texts, or letters).

duplicated at a reasonable fee. 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.,

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. Radiographs (x-rays) will be **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 a 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 may also 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.

Privacy Officer: Robert Orendor, DDS
Telephone: 207-384-2176
Fax: 207-384-1981

Address: 14 Highland Ave
So. Berwick,
ME 03908

South Berwick Dental

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

I hereby give my permission to discuss all aspects of my dental treatment to the individuals listed below:

______Mother______Father_______Wife______Husband_____Other (specify) ___________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, 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)

South Berwick Dental

SCHEDULING POLICY

We know that your time is important. Therefore, we make every effort to see all of our appointed patients at their appointed time. We are able to do this by working efficiently and not overbooking our providers. When an appointment is scheduled, we reserve the room, equipment, materials and time needed to address your specific dental needs. In return, we ask that you keep all scheduled appointments.

Rescheduling:

If you must change an appointment, please notify our office by phone **at least 48 hours** prior to your scheduled appointment.

*Please note we cannot accept appointment changes via e-mail, text, or voicemail.

Reminders/Confirmations:

We will use texts, phone calls or e-mails to remind you of upcoming appointments. Please reply with a confirmation so that we know to expect you (a confirmation will stop additional reminders).

*If your phone number changes, please notify our office at your earliest convenience.

Longer Appointments:

When scheduling a longer appointment, you may be notified that a confirmation is **required** to keep the appointment reserved.

Broken Appointments:

A broken appointment is considered any scheduled appointment for which you failed to show or a scheduled appointment that was cancelled less than 24 hours prior to the appointed time.

Multiple broken appointments will result is dismissal from the practice.

I have read and agreed to the above policy,

Patient:________________________________Date:_______________

OR

Guardian:______________________________Date: _______________

Time 3:28 PM

South Berwick Dental

Eaglesoft Medical History(Copy)

Date 3/3/2021

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question	Answer	
Are you under a physician's care now?	○Yes ○No	If yes
Have you ever been hospitalized or had a major operation?	○Yes ○No	If yes
Have you ever had a serious head or neck injury?	○Yes ○No	If yes
Are you taking any medications, pills, or drugs?	○Yes ○No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○Yes ○No	If yes
Do you use tobacco?	○Yes ○No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics
☐ No known allergies

Question	Answer	
Other Allergies?	○Yes ○No	If yes
Do you use controlled substances?	☐	If yes

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

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
AIDS/HIV Positive	○Yes ○No	Alzheimer's Disease	○Yes ○No	Anaphylaxis	○Yes ○No	Anemia	○Yes ○No
Angina	○Yes ○No	Arthritis/Gout	○Yes ○No	Artificial Heart Valve	○Yes ○No	Artificial Joint	○Yes ○No
Asthma	○Yes ○No	Behavior/Learning Problem	○Yes ○No	Blood Disease	○Yes ○No	Blood Transfusion	○Yes ○No
Brain Injury	○Yes ○No	Breathing Problems	○Yes ○No	Bruise Easily	○Yes ○No	Cancer	○Yes ○No
Cerebral Palsy	○Yes ○No	Chemotherapy	○Yes ○No	Chest Pains	○Yes ○No	Chicken Pox	○Yes ○No
Cold Sores/Fever Blisters	○Yes ○No	Congenital Heart Disorder	○Yes ○No	Convulsions	○Yes ○No	Cortisone Medicine	○Yes ○No
Diabetes	○Yes ○No	Drug Addiction	○Yes ○No	Easily Winded	○Yes ○No	Emphysema	○Yes ○No
Epilepsy or Seizures	○Yes ○No	Excessive Bleeding	○Yes ○No	Excessive Thirst	○Yes ○No	Fainting Spells/Dizziness	○Yes ○No
Frequent Cough	○Yes ○No	Frequent Diarrhea	○Yes ○No	Frequent Headaches	○Yes ○No	Genital Herpes	○Yes ○No
Glaucoma	○Yes ○No	Hay Fever	○Yes ○No	Hearing Problem	○Yes ○No	Heart Attack/Failure	○Yes ○No
Heart Condition	○Yes ○No	Heart Murmur	○Yes ○No	Heart Pacemaker	○Yes ○No	Heart Surgery	○Yes ○No
Heart Trouble/Disease	○Yes ○No	Hemophilia	○Yes ○No	Hepatitis A	○Yes ○No	Hepatitis B or C	○Yes ○No
Herpes	○Yes ○No	High Blood Pressure	○Yes ○No	High Cholesterol	○Yes ○No	Hives or Rash	○Yes ○No
Hypoglycemia	○Yes ○No	Irregular Heartbeat	○Yes ○No	Kidney Problems	○Yes ○No	Leukemia	○Yes ○No
Liver Disease	○Yes ○No	Low Blood Pressure	○Yes ○No	Lung Disease	○Yes ○No	Measles/Mumps	○Yes ○No
Mitral Valve Prolapse	○Yes ○No	Mononucleosis	○Yes ○No	Nervous/Anxious	○Yes ○No	Neurological Disorders	○Yes ○No
Osteoporosis	○Yes ○No	Pain in Jaw Joints	○Yes ○No	Parathyroid Disease	○Yes ○No	Psychiatric Care	○Yes ○No
Radiation Treatments	○Yes ○No	Recent Weight Loss	○Yes ○No	Renal Dialysis	○Yes ○No	Rheumatic Fever	○Yes ○No
Rheumatism	○Yes ○No	Scarlet Fever	○Yes ○No	Shingles	○Yes ○No	Sickle Cell Disease	○Yes ○No
Sinus Trouble	○Yes ○No	Spina Bifida	○Yes ○No	Stomach/Intestinal Disease	○Yes ○No	Stroke	○Yes ○No
Swelling of Limbs	○Yes ○No	Thyroid Disease	○Yes ○No	Tonsillitis	○Yes ○No	Tuberculosis	○Yes ○No
Tumors or Growths	○Yes ○No	Ulcers	○Yes ○No	Venereal Disease	○Yes ○No	Yellow Jaundice	○Yes ○No

Have you ever had any serious illness not listed above? ○Yes ○No If yes

Comments:

'o the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my esponsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:__________