## PATIENT INFORMATION

**Patient Name:** _____ **Social Security Number** _____

**Date of Birth (MM/DD/YYYY):** _____ **Sex: Male / Female**

**Address:** _____

_____

**Home Phone:** _____ **Work Phone:** _____ **Cell Phone:** _____

**E-mail Address:** _____

**Would you be interested in having communications sent to you via your e-mail address?** **YES / NO**

*Examples: appointment reminders, administrative updates and health bulletins

**How did you hear about our Practice?**

( ) Family/ Friends: Name_____ ( ) Google/Internet Search ( ) Passing by

( ) Through Zocdoc ( ) Through Insurance Carrier ( ) Other: _____

***Person responsible for payment and Insurance Information***

**Guarantor Name:** _____

Social Security Number: _____

Insurance Name: _____

Group #: _____ Member ID #:_____

Insurance Address: _____

Relationship to Patient: (please check): ( ) Self, ( ) Spouse, or ( ) Parent

Date of Birth (MM/DD/YYYY): _____ Sex: Male / Female

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer Name: _____ Employer Phone Number: _____

***Who to call for an emergency:***

Name: _____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

**IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMIBILE ACCIDENT?** **YES / NO**
**IF YES, PLEASE NOTIFY THE RECEPTIONIST.**

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Evergreen Dental, LLC. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

_____ _____

***Patient / Guardian Signature*** ***Date***

# MEDICAL HISTORY FORM

**Patient Name:** _____ **Date of Birth:** _____

Name of Medical Doctor: _____ Dr's Phone number:_____

**List all Medications or drugs you are currently taking:** ( ) None

_____

_____

**Check medications or drugs you are ALLERGIC to:**

( ) None
( ) Aspirin
( ) Codeine/ other narcotics
( ) Erythromycin
( ) Latex
( ) Local Anesthetics
( ) Metals
( ) Penicillin
( ) Sulfa Drugs
( ) Other: _____

**Women: Are you…**

( ) Pregnant / Trying to get pregnant?
( ) Nursing?
( ) Taking oral contraceptives?

**Check any Medical Conditions you may have:**

( ) None
( ) AIDS / HIV
( ) Alcohol / Drug Abuse
( ) Anemia / Leukemia
( ) Anorexia / Bulimia
( ) Arthritis
( ) Asthma / Hay fever
( ) BLOOD Clotting Problems
( ) Bronchitis
( ) Cancer / tumor or growth
( ) Cardiac Pacemaker
( ) Chest pain
( ) Damage Heart Valve
( ) Diabetes
( ) Emphysema
( ) Epilepsy
( ) Fainting Spells / Seizures
( ) Fever Blisters / Herpes
( ) Frequent Headaches
( ) Frequently Dry Mouth / Sjogren
( ) Gall Bladder Trouble
( ) Heart Attack / Stroke
( ) Heart Disease / Angina
( ) Hepatitis / Jaundice
( ) High Blood pressure
( ) Hives / Skin Rash
( ) Joint replacement, Date: _____
( ) Kidney / Bladder Trouble
( ) Liver Disease
( ) Low Blood Pressure
( ) Mental Health Problems
( ) Mitral Valve Prolapse
( ) Rheumatic fever
( ) Rheumatic Heart Disease
( ) Sinus Trouble
( ) Thyroid Problems
( ) Tuberculosis
( ) Other: _____

Tobacco use? If so what kind and how much? _____

Unusual reaction to DENTAL injections? _____

Reason for today's visit: _____

***NEW PATIENT:***

Name of former Dentist: _____ City/State: _____

Date of last cleaning and exam: _____

***By signing below, I certify all of the above information is true to the best of my knowledge.***

***Patient / Guardian Name (PRINTED)***: _____ ***Date***: _____

***Patient / Guardian Signature***: _____

***Doctor Signature:*** _____

# OUR OFFICE FINANCIAL POLICY

Thank you for choosing Evergreen Dental, LLC for your family's dental needs. We are committed to providing you with affordable and excellent dental care. Your trust is very important to us so our goal is to make sure you fully understand your treatment needs and financial responsibility before treatment begins. We will make every effort to work with you to ensure that your dental needs can be met.

**PAYMENTS**

Payment is expected at the time of service unless prior financial arrangements have been made. We offer several options:

1. Patients with insurance: co-pays, deductibles, and/or portion not covered by insurance are due at the time of treatment.
2. Patients without insurance: all payments for dental services rendered are due at the time of service.
3. We accept Visa, MasterCard, Discover and American Express.
4. Evergreen Dental, LLC has partnered with CareCredit, a patient financing company, to offer our patients 0% interest financing for 6 or 12 months with approval. No other payment plans are available.
5. There will be a minimum 60% down payment required at the time of service for any dental procedure that requires the service of a laboratory (crowns, bridges, dentures, etc.)

**PATIENTS WITH DENTAL INSURANCE**

As a courtesy to our insured patients, we will be happy to help file your dental insurance claims. However, please remember that your dental insurance policy is a contract between you, your employer and the insurance company. Although we agree to charge our fees to you based on your insurance fee schedule and help you file the claim, we are not a party to your insurance contract. Therefore, any payment that is not received from your insurance after 60 days from the treatment day will be due in full from you. You will then have to obtain reimbursement directly from your insurance company. Please understand that we cannot accept responsibility for collecting your insurance claim or for negotiating disputed claims between you and your insurance company.

**MISSED APPOINTMENTS**

Dr. Andy Huh reserves your appointment time exclusively for you. Your reserved time in our office is important. We understand that sometimes it is necessary to change your appointment so **we ask that you kindly give us a minimum of 1 business day notice**. Without this notice, we are unable to offer treatment to other patients that may have needed our care. If 2 or more appointments are broken in a 12 month period without 1 business day notice, all future appointments will be cancelled and patients will be placed on a "priority list" for their next visit.

***I have thoroughly read the Financial Policy. I understand and agree to this Financial Policy.***

***Patient / Guardian Signature:*** ***Date:***

# INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

**Please read and initial the items below and sign at the bottom of the form.*

**1. Treatment to be Provided**

I understand that during my course of treatment that the following care may be provided:

Examinations _____ Preventative Services _____ Restorations _____

Crowns _____ Bridges _____ Other _____ Patient Initials _____

**2. Drugs and Medications**

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Patient Initials _____

**3. Changes in Treatment Plan**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. Patient Initials _____

**4.** I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. Patient Initials _____

_____ _____

***Patient / Guardian Signature*** ***Date***

Evergreen Dental
790 Boston Rd.
Suite 201
Billerica
Massachusetts, 01821

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH AND MEDICAL 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 AND MEDICAL INFORMATION IS IMPORTANT TO US.

## OUR RESPONSIBILITIES

We at Evergreen Dental understand that medical information about you and your health is personal. Applicable federal and state law requires us 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 11/21/22, and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 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 may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**To Treat You:** We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Billing and Payment For Services:** We can use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We can use and disclose your health information in connection with our healthcare operations which 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 another 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 purposes without your written permission.

**Required by Law:** We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy 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.

**Respond to organ and tissue donation requests:** We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:**

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions:** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text messages 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, mailing, 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 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 at 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 by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

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: Dr. Andy Huh, DMD
Telephone: 9785283359
E-mail: hello@evergreendmd.com
Address: 790 Boston Rd.
Suite 201
Zip Code: 01821
State: Massachusetts
City: Billerica

**Evergreen Dental**
790 Boston Road Suite 201
Billerica, MA 01821

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement*

I have read/ or received a copy of this office's Notice of Privacy Practices.

Print Patient Name: _____

Patient/Guardian Signature: _____

Date: _____