

**CHICOPEE FAMILY DENTAL
ALL ANSWERS ARE STRICTLY CONFIDENTIAL**

PATIENT NAME: _____
DOB: _____

Date: _____
SSN: _____

MEDICAL CONDITIONS

TO THE PATIENT : Your answers are important for the protection on your health and that of the staff. Please answer

YES NO Hepatitis-Type A,B,C or Delta
YES NO Diabetes: insulin dependent or diet controlled
YES NO Patient in the hospital in the past 2 years
YES NO Artificial Joint Replacement
YES NO Kidney Disease/ Transplant/ Dialysis
YES NO Cancer: Type: _____
YES NO Chemotherapy/ Radiation Therapy Date: _____
YES NO Are you Allergic to any medicines ?
If YES, Please List Below:

YES NO Venereal Disease-Date _____
YES NO Do you use smokeless tobacco?
If YES, how frequently? _____
YES NO Are you undergoing Psychiatric Treatment?
YES NO Abnormal Bleeding
YES NO Are you Pregnant or Nursing?
If yes , Due Date: _____
And what trimester _____

YES NO High Blood Pressure
YES NO Asthma
YES NO Tuberculosis
YES NO Seizures
YES NO Stroke: Date: _____
YES NO Hyperthyroidism
YES NO Slow-Healing or Mouth Sores?
YES NO Do you smoke?
If YES, how much ?
YES NO Kidney Disease
YES NO Blood Disease? What kind? _____
YES NO Tested positive for HIV
If YES, Date: _____
YES NO Malignant Hyperthermia
YES NO Do you use Alcohol
If YES, how frequently? _____
YES NO Recurrent Illness?
YES NO Have you ever taken Fen-Phen for weight loss?

YES NO Are you taking any medications? If YES, Please list below:

Name of Drug:	Purpose :
_____	_____
_____	_____
_____	_____

Are You Allergic To Any Of The Following ? Please Circle:

- | | | |
|-------------------|-----------------------------|---------------------|
| Local Anesthetics | Barbiturates | Iodine |
| Sulfa Drugs | Sedatives | Penicillin or other |
| Latex Allergy | Codeine/Valium | Antibiotics _____ |
| Other: _____ | Aspirin, Ibuprofen, Tylenol | _____ |

Are you taking any of these Medications?

YES NO Antacids
YES NO Tagamet (Cimetidine) or Prilosec
YES NO Dilantin or Tegretol
YES NO Barbiturates
YES NO St. John's Wart or Kava-Kava
YES NO Cardizem (Diltiazem) or Calan, Isoptin (Verapamil)
YES NO Serzone (Nefazadone)
YES NO Diflucan (Fluconazole) or Sporonox (Itraconazole)
YES NO Biaxin (Clarithromyoin)

Heart Problem:

YES NO Murmurs
YES NO Bypass Surgery
YES NO Heart Attack - Date: _____
YES NO Pacemaker
YES NO Angina Pectoris
YES NO Rheumatic Fever
YES NO Artificial Valve Prolapse
YES NO Heart Stent? When placed?
YES NO Abnormal Heart or
YES NO Previous Bacterial Endocarditis

Please fill in the back page

Circle any of the following if you have had or have at present:

- | | | | | | |
|---------------|-----------------|----------------|--------------------|---------------|-----------------|
| Scarlet Fever | Ulcers | Emphysema | Cough | hemophilia | Thyroid Disease |
| Liver Disease | Alcoholism | Drug Addiction | Pain in Jaw | Birth Defects | Anemia |
| Sinus Trouble | Allergies/Hives | Cold Sores | Sickle Cell Anemia | Dizzy Spells | Seizures |
| Bruise easy | Nervousness | Fainting | Mental Retardation | Hay Fever | Cortisone Meds. |
| Epilepsy | Glaucoma | Rheumatism | Arthritis | Cancer | |

MEDICAL HISTORY

When was your last physical examination? _____ Physician's Name? _____
 Has there been any change in your general health in the past year ? _____ If yes, for what reason ? _____
 Are you now under a physician's care? _____ If yes, for what condition ? _____
 Is there anything related to your medical history that you have not indicated above? If yes, please explain: _____

DENTAL HISTORY

When was your last professional cleaning /exam _____ , X- rays _____
 What is your concern? _____

- YES NO Are you having pain or discomfort at this time?
 YES NO Do you feel nervous about dental treatment?
 YES NO Do you have trouble chewing?
 YES NO Have you ever had orthodontic treatment?
 YES NO have you been advised to take antibiotics prior to dental treatment?
 YES NO Have you been told you have gum disease?
 YES NO Do you dislike anything about your smile?
 YES NO Do your gums bleed when you floss or brush?
 YES NO Do you have dental implants?
 YES NO Do you have frequent headaches?

Patient's Comments: _____

Dr Comments: _____

Patient's Signature: _____

Dr Signature: _____

REGISTRATION HISTORY

DATE _____

PATIENT'S NAME _____ SINGLE _____

WIDOWED _____

NAME OF SPOUSE _____ MARRIED _____

DIVORCED _____

SEPARATED _____

IF A CHILD, PARENT'S NAME _____

STREET ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

PATIENT EMPLOYED BY _____ PHONE _____

BUSINESS ADDRESS _____

PRESENT POSITION _____ HOW LONG HELD _____

SPOUSE EMPLOYED BY _____ PHONE _____

BUSINESS ADDRESS _____

PRESENT POSITION _____ HOW LONG HELD _____

PURPOSE OF THIS APPOINTMENT _____

IN CASE OF EMERGENCY, WHOM SHOULD BE NOTIFIED _____ PHONE _____

PERSON RESPONSIBLE FOR PAYMENT _____

DO YOU HAVE ANY INSURANCE THAT MAY COVER ANY PART OF OUR PROFESSIONAL SERVICES YES _____ NO _____

IF SO, NAME OF COMPANY _____ POLICY NO _____

IF INSURANCE COVERED, SOCIAL SECURITY NO. OF PERSON COVERED _____

(IT IS NECESSARY THAT YOU PROVIDE INSURANCE CARDS FOR ALL PROFESSIONAL SERVICES THAT MAY BE ELIGIBLE FOR INSURANCE COVERAGE)

WHOM MAY WE THANK FOR REFERRING YOU _____

COMMENTS: _____

CHICOPEE FAMILY DENTAL
Dr. Bash,A & Dr.L'heureux,R
30.SAINT JAMES AVENUE
CHICOPEE,MA 01020
Tel: 413-592-2177

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.

(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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

CHICOPEE FAMILY DENTAL
Dr. Bash, A & Dr. L'heureux, R
30 SAINT JAMES AVENUE
CHICOPEE, MA 01020
Tel: 413-592-2177

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 04/14/2003, 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 \$2.00 for each page, \$25.00 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: Dr. RICHARD M. L'HEUREUX _____

Telephone: 413-592-2177 _____ Fax: 413-592-3278 _____

E-mail: drmrlheureux@charter.net _____

Address: 30 St. James Ave, Chicopee, MA 01020 _____

