Attleboro Family Dental Care
Dr. Hikmat Hannawi
550 North Main Street
Attleboro, MA 02703
508-222-2510

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Attleboro Family Dental Care. I hereby authorize, as indicated by my signature below, to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient consent form.

_____ _____
Print Name **Address**

_____ _____
Signature **Date**

Please check your preferred means of communication:

- o You may contact me at my home telephone number_____
- o You may contact me on my mobile telephone number _____
- o You may contact me on my work telephone number _____
- o You may send me an email at: _____
- o Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added / Removed: _____
2. _____ Date Added / Removed: _____
3. _____ Date Added / Removed: _____
4. _____ Date Added / Removed: _____

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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:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining the acknowledgement
- o Other (Please Specify) _____
- o Staff Person Initials _____

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Here at Attleboro Family Dental Care, we have an array of services to provide to our patients. We strive to consistently deliver exceptional customer service as well as high quality dental procedures. Our dental team prides itself on offering you the best that dentistry has to offer.

Our goal is to exceed your expectations. We ask you to please take the time to fill out the following paperwork today. This will enable us to learn more about you, and how we can help you achieve optimal dental health as well as achieve your perfect smile! Thank you.

Date: _____

Patient's name: _____
First Last Middle

Patient's Address: _____
Street City State/Zip

_____ _____
Home Phone Cell Phone

_____
Sex Marital Status Place of Employment

_____ _____
Date Of Birth Email Address

_____ _____
Social Security No. Referred By

Insurance Information

Dental Insurance Company: _____ Subscriber ID: _____

Subscriber's Name: _____ Subscribers Date of Birth: _____

Subscriber's Place of Employment: _____ Group No.: _____

Medical Insurance Company: _____ Subscriber ID: _____

Attleboro Family Dental Care

Cancellation and No Show Policy

We understand that your time is valuable and our schedulers work very carefully to appoint and reserve chair time for your dental treatment. Without enough notice to adjust our schedule, due to a failed appointment, a delay in treatment for you and other patients may occur.

Your scheduled appointment is a reserved amount of time in the doctor or hygienist chair. When a patient fails to keep their appointment without 48 hour notice, the office, doctor, hygienist, and patients waiting for an appointment are all affected. Therefore, **all failed appointments will be charged a $100 cancellation fee.**

Radiography Policy

In order to complete a proper examination and to properly diagnose, a full mouth X-ray series is required on the day of your appointment. If you were asked to obtain your recent X-ray images from a previous dentist and they are not of diagnostic quality, we reserve the right to retake the necessary X-rays at the patient's expense at the time of service.

Financial Agreement Policy

It is the policy of Attleboro Family Dental Care to **collect 50% of the total patient balance at time of scheduling and reserving doctor or hygienist time for certain procedures.** We will require our patients to sign a financial agreement after the treatment plan has been presented, reviewed and agreed to by patient.

Patient Name_____

Patient Signature_____

Date_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To 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 responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Attleboro Family Dental Care
Dental Health Questionnaire

Mark your appropriate answer	Yes	No
Are you pleased with the appearance of your teeth and smile?		
Are you apprehensive about dental treatment?		
Do you have difficulty chewing your food?		
Do your gums bleed easily?		
Do you feel, or have been told, that you have gum disease? (Periodontal Disease)		
Are your teeth sensitive?		
Do you feel pain when your teeth come in contact with hot or cold liquids?		
Do you feel pain when your teeth come in contact with sweets or sours?		
Does your jaw make a noise or get stuck so that you can't open it freely?		
Do you have pain in the face, cheeks, jaw, or throat?		
Do you have temporomandibular disorder? (TMD)		
Have you had a blow to the jaw? (Trauma)		
Does jaw pain or discomfort affect your sleep?		
Would you like your teeth to be whiter?		
Do you gag easily?		

Please utilize the bottom of this paper to explain your dental expectations, and how we can better serve you:

PATIENT CONSENT

Clinical

1. I authorize, **Attleboro Family Dental Care**, to perform all recommended treatment.

2. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.

3. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

4. I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a 1.5% MPR or 18% APR automatically tabulated into my account if my balance is 30 days old or older. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

Insurance

5. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.

6. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

I have read this Patient Consent and agree to all terms and conditions herein.

Patient's Name: _____ Date: _____

Patient's Address:_____