## PATIENT INFORMATION

Date:_____ SS#_____

Patient:_____

Address:_____

_____

City State Zip code

Phone: (____)_____

Cell Phone: (____)_____

Birth date:_____

Sex: ☐M ☐F Age:_____

E-mail:_____

Employer:_____

Employer's Address:_____

_____

Employer's Phone: (____)_____

Whom may we thank for referring you?

_____

## DENTAL INSURANCE

Do you have dental insurance? ☐Yes ☐ No

Dental Carrier: _____

Group number: _____

Subscriber number: _____

Insurer's Name:_____

Insurer's Employer: _____

*Insurer's DOB:_____

*Insurer's SS #: _____

## ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with

_____

and assign directly to Dr. Coravos all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all insurance and any costs not covered by insurance. I hereby authorize the dental office to release all information necessary to secure the payment of benefits, including the debiting of my credit card post 90 days of treatment. I authorize the use of this signature on all insurance submissions. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I acknowledge that the dental office has the authorization to obtain a credit report from Equifax Credit Services when deemed necessary. In addition, the dental office may charge a broken appointment fee when scheduled treatments are cancelled the same day or missed without prior notification. An 18% finance charge will be added to any balance not paid in full within 30 days. The information on this page and the medical history are correct to the best of my knowledge.

I have received a copy of this office's Notice of Privacy Practices. Yes No

Responsible Party Signature: _____

Print name: _____

Relationship: _____

Date: _____

## Health History

Have you ever had any of the following? Please check ( ) those that apply:

Rheumatic fever? Yes No

Diabetes? Yes No

Epilepsy? Yes No

High Blood Pressure? Yes No

Respiratory Disease? Yes No

Prolonged Bleeding? Yes No

Healing complication? Yes No

HIV? Yes No

Cancer? Yes No

### Pre-med:

Do you need any pre-medication for dental treatment? Yes No

To the best of your knowledge, are you or have you ever been afflicted with a heart ailment or heart murmur? Yes No

If so, please specify_____

_____

### Women:

Are you pregnant? Yes No

Due Date:_____

Are you nursing? Yes No

Are you taking birth control pills? Yes No

### MEDICATIONS

List any medications you are currently taking and the correlating diagnoses:_____

_____

_____

_____

### ALLERGIES

Penicillin Latex

Amoxicillin Barbiturates (sleeping pills)

Aspirin Sulfa

Codeine Local Anesthetic

Other_____

Are you currently under a physician's care? Yes No

Reason_____

_____

## Dental History

Please check ( ) if you have had any of the following:

Are your teeth sensitive to:

Heat? Yes No

Cold? Yes No

Sweets? Yes No

Biting pressure? Yes No

Do you feel you will eventually wear artificially dentures? Yes No

Have you had a reaction to local anesthetic? Yes No

Have you ever had any teeth removed? Yes No

If so, when were they removed?_____

When was your last dental appointment?

_____

Do you have any general health problems? Yes No

If so, please specify_____

_____

Do you smoke? Yes No

Do you have an unpleasant taste or odor in your mouth? Yes No

How would you rate your smile?
10 being the best.

1 2 3 4 5 6 7 8 9 10

Please visit us on the web:
www.Coravos.com

Or e-mail us at:
Smile@coravos.com

**HIPAA PRIVACY FORM 1**

# Notice Of Privacy Practices

**Purpose**: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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# 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 (MM/DD/YR), 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 $0.___ for each page, $___ 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: Allyson Fortune

Telephone: 978-458-4921 Fax: 978-458-8864

E-mail: Smile@Coravos.com

Address: 75 Arcand, Drive Lowell, MA. 01852

**HIPAA PRIVACY FORM 2**

# Acknowledgement of Receipt of Notice of Privacy Practices

**Purpose**: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.



## 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}

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**For Office Use Only**

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

_____

_____

_____