WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date: _____

E-Mail Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: _____ Age: ____ SS#: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: _____ Pager / Cell #: _____

Wk #: _____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

☐ Previous ☐ Present Dentist: _____

Last Visit Date: _____

2 SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: _____ Ext: ____ SS #: _____

Birthdate: _____ DL #: _____

Person Responsible for Account: _____

Wk #: _____ Ext: ____ Hm #: _____

Billing Address: _____

Relationship: _____ SS #: _____

Employer: _____ DL #: _____

3 INSURANCE

Primary Insurance

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Neighbor or Relative not living with you.

His / Her Name: _____ Relation: _____

Wk #: _____ Hm #: _____

Address: _____

_____
City State Zip

4 MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Are you currently under the care of a physician? Yes No

Please explain: _____

CONTINUED ON BACK

4 MEDICAL HISTORY CONTINUED

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter or herbal supplemental drugs? ☐ Yes ☐ No

Please list each one:

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you ever taken Phen-Fen? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems

☐Y ☐N Abnormal Bleeding	☐Y ☐N Herpes / Fever Blisters
☐Y ☐N Alcohol / Drug Abuse	☐Y ☐N High Blood Pressure
☐Y ☐N Anemia	☐Y ☐N HIV+ / AIDS
☐Y ☐N Arthritis	☐Y ☐N Hospitalized for Any Reason
☐Y ☐N Artificial Bones/Joints/Valves	☐Y ☐N Kidney Problems
☐Y ☐N Asthma	☐Y ☐N Liver Disease
☐Y ☐N Blood Transfusion	☐Y ☐N Low Blood Pressure
☐Y ☐N Cancer /Chemotherapy	☐Y ☐N Lupus
☐Y ☐N Colitis	☐Y ☐N Mitral Valve Prolapse
☐Y ☐N Congenital Heart Defect	☐Y ☐N Osteoporosis / Paget's Disease
☐Y ☐N Diabetes	☐Y ☐N Pacemaker
☐Y ☐N Difficulty Breathing	☐Y ☐N Psychiatric Problems
☐Y ☐N Emphysema	☐Y ☐N Radiation Treatment
☐Y ☐N Epilepsy	☐Y ☐N Rheumatic / Scarlet Fever
☐Y ☐N Fainting Spells	☐Y ☐N Seizures
☐Y ☐N Frequent Headaches	☐Y ☐N Shingles
☐Y ☐N Glaucoma	☐Y ☐N Sickle Cell Disease / Traits
☐Y ☐N Hay Fever	☐Y ☐N Sinus Problems
☐Y ☐N Heart Attack	☐Y ☐N Stroke
☐Y ☐N Heart Murmur	☐Y ☐N Thyroid Problems
☐Y ☐N Heart Surgery	☐Y ☐N Tuberculosis (TB)
☐Y ☐N Hemophilia	☐Y ☐N Ulcers
☐Y ☐N Hepatitis	☐Y ☐N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following?

☐Y ☐N Aspirin	☐Y ☐N Erythromycin	☐Y ☐N Tetracycline
☐Y ☐N Codeine	☐Y ☐N Latex	☐Y ☐N Other
☐Y ☐N Dental Anesthetics	☐Y ☐N Penicillin	

Please list any other drugs/materials that you are allergic to:

5 DENTAL HISTORY

Why have you come to the dentist today?

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you have fears about going to the dentist? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Y ☐ N Do your gums ever bleed? ☐ Y ☐ N

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

How long do you use a toothbrush before replacing it? _____

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? ☐ Yes ☐ No If yes, why? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____

Signature Date

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____

Signature Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

Michael R Dion DMD
Family, Preventative and Cosmetic Dentistry
24 Pinkerton St
Derry, NH 03038
(603) 434-0040

HIPPA PRIVACY POLICY
PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected dental information to carry out:

--Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment.
--Obtaining payment from third party payers (i.e. my insurance company)
--The day to day dental healthcare operation of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my protected dental health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health Information is used and disclosed to carry out treatment , payment, and health care operations, but that you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or Disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient name_____

Relationship to Patient_____

Signature_____

Date_____

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HIPAA Release of Health Information

The Health Insurance Portability and Accountability Act (HIPAA) is a law implementing national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. This form allows the disclosure and authorization of your personal health information to be released to whom you specify. This may include X-Rays, treatment plans, financial records, and other information pertaining to your record with Dr. Michael R Dion DMD. Please list the **full name and relationship** of recipients whom you would like us to have permission to disclose your information to:

1. _____

2._____

3._____

This authorization will remain in effect until further notice. You may revoke authorizations at any time by written or electronic note explaining the changes in the authorization. Please send to our mailing address above or email to trisha@diondmd.com. Signing this form is voluntary and indicates you have read and understand the HIPAA law and authorize the disclosure of personal health information to specified parties in this form.

Name:_____ Patient/Guardian

Signature:_____ Date:_____

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Office Financial Policy

As a courtesy, we will process your insurance benefits to help relieve you of this consuming sometimes-complicated task.
I agree that I am fully responsible for the total payment of all procedures in this office-this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that all services are due to be paid in full within sixty days of the date of service, regardless of whether or not my insurance benefits have been received. We have many payment options; cash, check, most major credit cards, and care credit. Our office can assist you with information and applying for care credit.

MISSED APPOINTMENTS

Appointment times are reserved especially for you. If for any reason you should need to change your appointment, we require a 24 hour notice. There will be a **$50 fee** for missed and last minute cancellations. Please help us serve you better by keeping your appointments.

Dr. Dion reserves the right to deny service to patients that continually violate the broken appointment policy. In order to ensure that our patients receive the best care possible, it is necessary to enforce this policy. However, we do understand that emergency situations may arise; therefore the office has the right to make exceptions when necessary.

CONSENT TO DENTAL PHOTOGRAPHY

In connection with my dental service, which I am receiving from Dr. Dion, I agree and consent to allow the photographs taken before, during, and after completion of my dental treatments, may be used for dental records, research, education, public relations, patient counseling, or other purposes.

Signature (responsible party) _____

Date_____