Boston SMILE center & Laser Dentistry

ALAN SASSON, D.M.D.

PERSONAL INFORMATION

ABOUT YOU

Date _____

Patient Name _____

I prefer to be addressed as _____

Date of Birth _____

Social Security No. _____

Please check: ☐ Male ☐ Female

☐ Child ☐ Single

☐ Divorced ☐ Married

☐ Widowed ☐ Domestic Partnered

Home Address _____

City, Zip _____

Cell No. _____

Home No. _____

Work No. _____ EXT _____

May we contact you at this work phone? ☐ Yes ☐ No

Email address _____

We send appointment confirmation through email and text. Please select one or both: ☐ Email ☐ Text

If you do not have either, indicate which number to reach you:

_____

Employer _____

Occupation _____

Who may we thank for referring you to us?

_____

EMERGENCY CONTACT

In the event of an emergency, is there someone you would like us to contact?

Name _____

Relation _____

Phone No. _____

MEETING PATIENT'S IMMEDIATE NEEDS

What brings you here today: ☐ Check-up ☐ Problem

☐ Other (Explain): _____

Why are you changing dental offices?

☐ Insurance ☐ Location ☐ Schedule ☐ Didn't like

☐ Other (Explain): _____

Do you have problems with your teeth now?

☐ Yes ☐ No

If yes, please check: ☐ Hot ☐ Cold ☐ Sweet

☐ Food-Caught ☐ Broken Tooth ☐ Other: _____

_____

Would you like to speak in private with the doctor about any problems? ☐ Yes ☐ No

WHAT CONCERNS YOU?

☐ Discomfort ☐ Cost ☐ Time ☐ Inconvenience

☐ Afraid ☐ Other: _____

_____

I authorize the release of any information relating to claims filed by **BOSTON SMILE CENTER.**

Signature _____

I wish to assign benefits to **BOSTON SMILE CENTER** and understand that I am responsible for any co-payment and deductibles that my insurance does not cover.

Signature _____ Date _____

DENTAL INFORMATION

Boston SMILE & center Laser Dentistry

PAST DENTAL HISTORY

When was the last time you saw a dentist?

☐ Less than 1 year ☐ 1 to 2 years ☐ 3+ Years

Former Dentist _____

Office Location _____

Last Visit Date _____

What treatment did you receive?

☐ Check-Up ☐ Basic Fillings ☐ Major Dental Work

Was that a comfortable experience? ☐ Yes ☐ No

Why? _____

Did you have any treatment that was recommended but not yet completed? ☐ Yes ☐ No

If yes, please explain: _____

_____

COSMETIC DENTISTRY

Would you like whiter teeth? ☐ Yes ☐ No

Is there anything in your smile you would like to change if you could?

☐ Color ☐ Shape ☐ Position ☐ Straighter

☐ Replace Missing Teeth

☐ Other: _____

HOME CARE AND PERIODONTAL HISTORY

What do you do at home to take care of your oral health?

☐ Mouthwash ☐ Brush; how often? _____

☐ Floss; how often? _____

Do your gums bleed when you brush and/or floss your teeth? ☐ Yes ☐ No

Are you concerned about? ☐ Bad Breath ☐ Taste

☐ Other; explain: _____

_____

ALLERGIES

Please circle if you have any allergies to the following:

Amoxicillin ☐	Anesthetics ☐	Novocaine ☐
Metals/Jewelry ☐	Penicillin ☐	Sulfa ☐
Tetracycline ☐	Aspirin ☐	Codeine ☐
Erythromycin ☐	Latex ☐	

Other (explain): _____

_____

LIFETIME SMILE PLAN

We will always educate you about the health of your mouth and provide you with treatment options so you can make informed choices. Our mission is to partner with you to ensure a successful plan for attaining and maintaining optimum oral health that will keep you smiling for a lifetime.

DO YOU HAVE ANY QUESTIONS FOR THE DOCTOR ?

_____

_____

_____

_____

_____

_____

_____

HEALTH INFORMATION

Boston SMILE & center Laser Dentistry

HEALTH HISTORY

Today's Date _____

Patient Name _____

Patient's Date of Birth _____

Personal Physicians Name _____

Office Location _____

Phone No. _____

Please list any serious illness that you have been hospitalized for in the last 5years: _____

_____

_____

_____

Please list all the medications you are currently taking (include over-the-counter medications):

Medication	Reason

Are your taking birth control pills? ☐ Yes ☐ No

Could you be pregnant? ☐ Yes ☐ No

Are you currently nursing? ☐ Yes ☐ No

Have you taken osteoporosis treatment drugs? ☐ Yes ☐ No

Have you ever or are you taking blood thinners? ☐ Yes ☐ No

Are you taking any supplements? ☐ Yes ☐ No

PRE-MEDICATIONS

Antibiotic pre-medication may be necessary if you have had or currently have the following: (Please circle)

1. Prosthetic cardiac valve ☐
2. Previous bout of infective bacterial endocarditis ☐
3. Cardiac transplant patients who have had valvulitis ☐
4. Congenital heart disease excluding mitral valve prolapse ☐
5. Joint replacements ☐

If you require pre-medication, please indicate what medicine you take? _____

HEALTH CONDITIONS

Please circle if you have ever had any of the following diseases or medical conditions:

HIV / AIDS	☐	Cold Sores / Herpes	☐
Acid Reflux	☐	Headaches (Severe, Frequen	☐
Migraines	☐	Hemophilia	☐
Diabetes	☐	Snoring / Sleep Apnea	☐
Smoking / Tobacco	☐	Drug / Alcohol Abuse	☐
Difficulty Breathing	☐	Angina	☐
Arthritis	☐	Artificial Heart Valves	☐
Hips or Joints	☐	Asthma / Hay Fever	☐
Blood Transfusions	☐	Cancer / Chemotherapy	☐
Congenital Heart Defect	☐	Emphysema	☐
Gastrointestinal Disorder	☐	Surgeries	☐
Glaucoma (Narrow Angle)	☐	Hearing-Impaired	☐
Heart Attack	☐	Heart Murmur	☐
Heart Surgery	☐	Anemia	☐
Hepatitis A B C D	☐	High / Low Blood Pressu	☐
Liver Disease	☐	Kidney Problems	☐
Mitral Valve	☐	Prolapse	☐
Pacemaker	☐	Radiation Treatments	☐
Stroke	☐	Shingles	☐
Sinus Problems	☐	Thyroid Problems	☐
Tuberculosis	☐	Tumor Growth	☐
Ulcers	☐	Venereal Disease	☐

Rheumatic / Scarlet Fever ☐

Alzheimer's / Memory Loss ☐

Stents Placed in Heart (Date _____)

Epilepsy/ seizures/Fainting (Date last episode: (_____)

Other (s): _____

I hereby certify that the information I have given here today is correct to the best of my knowledge.

Signature _____

Date _____

BOSTON SMILE CENTER CONSENTS

Boston SMILE center & Laser Dentistry

CONSENT FOR DENTAL TREATMENT

1. I authorize the doctor or designated staff to take x-rays and/or use any other diagnostic aid deemed appropriate by the doctor to make a thorough diagnosis of my dental condition and needs.
2. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon.
3. I agree to the use of anesthetics and/or other medications as necessary. I fully understand that utilizing anesthetics entails certain risks. I understand that I can ask for a complete description of any possible complications.
4. I agree to have BOSTON SMILE CENTER share my dental and medical information with other specialists as necessary for my treatment.
5. I agree to keep my reserved dental appointments. If I must cancel an appointment, I agree to give at least 2 business days notice or a cancellation charge may apply.

Signature _____ Date _____

CONSENT FOR USE OF PHOTOS

In consideration of One Cent of a Dollar ($0.01), receipt of which is acknowledged, I do hereby give BOSTON SMILE CENTER- Alan Sasson, D.M.D. the irrevocable right to use my name, pictures, portraits or photograph in all forms and media and all manners for advertising, trade, or other lawful purpose, and waive any right to inspect or approve the finished product, including written copy, that may be created therewith. I am of legal age.

In signing on behalf of a minor, or myself, I have the legal authority to execute the above release. I have read this release and I consent to its terms.

Signature _____ Date _____

FINANCIAL DISCLAIMER

I agree to unconditionally pay for services rendered, irrespective of payment by insurance carriers, workers' compensation and the like. I also agree to pay for services at the time they are rendered unless other arrangements have been made with the financial coordinator in advance. I understand that financial charges may be added to my account for delinquent payments. I understand that there can be no guarantee of outcome with my dental procedure and acknowledge no guarantee has been made to me with regard to the procedures I have authorized. I further acknowledge that I have been given full opportunity to discuss the matters contained herein with J. Alan Sasson, D.M.D., his associates or assistants and that I understand the information provided.

Signature _____ Date _____

J Alan Sasson, D.M.D.
12 Webster Street
617-739-1017
Brookline MA 02446

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.

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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.

J. Alan Sasson, DMD

12 Webster Street

Brookline, MA 02446

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}

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

_____

_____

J. Alan Sasson, D.M.D.

12 Webster Street
Brookline, MA 02446

617-739-1017

Financial Policy

Thank you for choosing us as your dental health care provider. We are committed to the success of your dental treatment and want to provide you with the best service possible. To help reduce our administrative costs and keep our fees to you as low as possible, we require payments to be made at or prior to the time that you (or your family members) receive treatment. Please indicate below your preferred method(s) of payment.

My preferred payment option is:

_____ Cash

_____ Check

_____ Major Credit Card (Visa, MasterCard, American Express)

_____ ****

A note for patients with dental insurance

Dental insurance normally does not cover the total cost of your treatment. Based on your plan, we usually can **estimate** the amount of your co-payment. Your co-payment is expected when treatment is delivered. If your insurance company fails to pay within 60 days after we submit your claim, you will be responsible for the full fee.

*** For treatment amounts over $300, please inquire about the possibility of an extended payment plan.

Acceptance Agreement

I understand and agree with the above financial policy. I understand the parent or relative bringing a child for dental treatment is responsible for all fees incurred at that visit. I further understand that I am responsible for ALL fees, regardless of insurance coverage.

Patient/Responsible Party _____ (Printed Name)

_____ (Signature)

_____ (Date)