PATIENT REGISTRATION

First Name: ________________________ Last Name: ________________________ Middle Initial: ____

Patient Is: ˇ Policy Holder Preferred Name: ________________________

ˇ Responsible Party

Patient Information

Address: ________________________ Address 2: ________________________

City, State, Zip: ________________________ Pager: ________________________

Home Phone: ______________ Work Phone: ______________ Ext: ________ Cellular: ______________

Sex: O Male O Female Marital Status: O Married O Single O Divorced O Separated O Widowed

Birth Date: ______________ Age: ________ Soc Sec: : ______________

E-mail: ________________________ ˇ I would like to receive correspondences via e-mail

Employment Status: O Full Time O Part Time O Retired

Student Status: O Full Time O Part Time

Occupation: ______________ Pref. Dentist: ______________

Pref. Pharmacy: ______________

To whom may we thank for referring you to us: ________________________

Responsible Party (if someone other than the patient): PARENT OR LEGAL GUARDIAN - PRESENT

First Name: ________________________ Last Name: ________________________ Middle Initial: ____

Address: ________________________ Address 2: ________________________

City, State, Zip: ________________________ Pager: ________________________

Home Phone: ______________ Work Phone: ______________ Ext: ________ Cellular: ______________

Birth Date: ______________ Soc Sec: : ______________

O Responsible Party is also a Policy Holder for Patient O Primary Insurance Policy Holder O Secondary Insurance Policy Holder

Primary Dental Insurance Information

Name of Insured: ________________________ Relationship to Insured: O Self O Spouse O Child O Other

Insured Soc. Sec: ______________ Insured Birth Date: ______________

Employer: ________________________ Ins. Company: ________________________

Address: ________________________ Address: ________________________

Address 2: ________________________ Address 2: ________________________

City, State, Zip: ________________________ City, State, Zip: ________________________

Secondary Dental Insurance Information

Name of Insured: ________________________ Relationship to Insured: O Self O Spouse O Child O Other

Insured Soc. Sec: ______________ Insured Birth Date: ______________

Employer: ________________________ Ins. Company: ________________________

Address: ________________________ Address: ________________________

Address 2: ________________________ Address 2: ________________________

City, State, Zip: ________________________ City, State, Zip: ________________________

Charges for services are the patient's and/or responsible party's responsibility. Confirmation of services covered by insurance are the responsibility of the patient and/or responsible party. Patient authorizes and directs dental benefit payments to Drs. Goodman & Ko. Any portion of the balance not paid by insurance is the patient's and/or responsible party's full responsibility. A finance charge of 1% per month (12% annually) will be assessed on all past-due accounts. The undersigned Patient or Responsible Party agrees to any and all collection fees, court costs, and attorney's fees in the event a third party agency or lawsuit is necessary to enforce payment for services. Any services rendered by this office will be assumed to be authorized on these terms.

________________________ ________________________ ____________

Patient/Responsible Party Print Name Date

NAME: ______________________________ **DATE:** ____________

MEDICAL HISTORY

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.

Question	Answer	Details
Do you have a Primary Care Doctor? If so, name and phone number.	O Yes O No	____________ ____________________
Have you ever been hospitalized or had a major operation? And Why?	O Yes O No	If yes, please explain: ____________
Have you ever had a serious head or neck injury?	O Yes O No	If yes, please explain: ____________
Please list any over the counter or prescription medication, pills or drugs that you are taking.	O Yes O No	If yes, please explain: ____________
Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates	O Yes O No	If yes, please explain: ____________
Do you use smoke or smokeless tobacco?	O Yes O No	If yes, please explain: ____________

Women: Are you

Pregnant/trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following?

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

ˇ Other If yes, please explain: ______________________________

Do you have, or have you ever been treated for, any of the following?

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

Have you ever had any serious illness not listed above? O Yes O No If yes, please explain: ______________________

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 ______________

PATIENT:________________________________ ______________________________ Date: ___________________

DRS. GOODMAN, KO & BRESSLER

192 West Street

Milford, Massachusetts 01757

(508) 478-3800

NEW PATIENT EXAMINATION FORM

#1 DENTAL HISTORY

A. Can you summarize for us what brings you to the office today? ______________________________

____

B. Have you had any problems with past dental treatment that we should know about? _____________

____

____

C. Last dental cleaning/exam date?____

D. Are you presently having any toothaches or problems that you wish for us to evaluate? __________

E. Are there any aspects of your smile you don't like and wish for us to address? _________________

____

Would you like whiter teeth if it was easily obtainable? Yes No

F. On a scale of 1 to 10, how would you rate: (1 = low 10 = high)

i. Your overall dental health now? __________

ii. The stability and comfort of your bite? __________

iii. The esthetics of your smile? __________

iv. Your previous dentist and the level of care received? __________

#2 TMJ SCREENING HISTORY

A. HISTORY

Have you ever had a problem with your TMJ's (jaw joint)?	Yes	No
Have you ever had an injury to the jaw?	Yes	No

B. PAIN OR TENDERNESS

Do your jaw joints ever hurt or become tender when you chew, talk, or open wide?	Yes	No

C. JOINT SOUNDS/JAW LOCKING

Do you hear any clicks, pops, or grating sounds in your jaw joints?	Yes	No
Were there ever any such sounds in the past, and are they now gone?	Yes	No
Does your jaw ever get stuck, or locked open or closed?	Yes	No

D. DIFFICULTY OPENING/CHEWING

Do you have any difficulty opening your jaw?	Yes	No
Do you have any problems with the muscles of your jaw getting tired when you eat or chew food?	Yes	No

Dental photographs may be taken during treatment for teaching, educational or marketing purposes.

INITIAL:____________

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a %friendly+version. A more complete text is posted in the office.
What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov
We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient¢s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ____________________________________date___________do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

DRS. GOODMAN, KO & ASSOCIATES, LLP
192 WEST STREET
MILFORD, MA 01757

PAYMENT POLICY

Welcome to our dental office. Thank you for choosing us as your Dental Provider.

Our office financial policy is intended to provide you with a clear understanding of your responsibility for payment of services rendered.

If you are a self-paying patient:

- Payment is due at time of service.
- For your convenience, we accept cash, check, debit and major credit cards.

If you have insurance:

- All co-pays are due at time of service.
- We will file your charges with your insurance.
- You will receive a statement for any amount remaining after insurance has paid. This will be due from you.
- Your dental insurance plan is a contractual agreement between you and your dental insurance company, not our office. Please be advised that you are ultimately responsible for your bill. Payment is not contingent or dependent on your insurance company.
- I authorize and direct payment of dental benefits, otherwise payable to me, to Drs. Goodman & Ko

THANK YOU FOR SIGNING BELOW AND ACKNOWLEDGING OUR PAYMENT POLICY.

Name:____

Date: ____

Insurance Information

Please bring your insurance card with you to each visit

Name of Insurance: ___________________________ Subscriber ID #____________________

Name of Policy Holder and Relationship: ____

Group Number: ____________________

DRS. GOODMAN, KO & ASSOCIATES, LLP

192 WEST STREET

MILFORD, MA 01757

(508) 478-3800

info@goodmanko.com

WELCOME

As a new patient in our office, we will need to take x-rays. X-rays allow us to see in and around a tooth that the dentist cannot see with his/her naked eye.

If you have had a full mouth or pan x-ray within the last 3 – 5 years and you had the same insurance company and/or same employer that you have today, we need to obtain a copy of these films. If x-rays are taken and your insurance company denies the claim, the cost of the x-rays will become a patient liability.

Please complete the information below and forward to your former dentist.

Date: _______________

Previous dentist name: ____ Phone: _______________

Email: ____

Address: ____

Patient name: ____

Patient signature: ____

The above mentioned patient has requested that you transfer records/x-rays. If possible, we prefer x-rays to be sent via email (Info@goodmanko.com)

Thank you