Jimish Patel, DMD
436 Broadway – Village Mall
Methuen, MA 01844

WELCOME!

We would like to welcome you to our dental practice and explain a little about our office policies and goals. We believe in the theories of modern dental care which do not support the old premise of "When it hurts – fix it". Through proper preventative care and regular checkups, we believe that it is highly likely that most of our patients can expect to keep all of their teeth for many years to come.

Our patients can expect from us:

1. A high degree of professional skill and ability.
2. A dedication to your oral healthcare.
3. A minimization of costly reconstructive work through proper preventative care.
4. The highest effort to make your visits as comfortable as possible.
5. The right treatment at the right time.
6. Fees that are fair and just for the services provided.

In return, we expect from our patients:

1. Cooperation in making and keeping appointments.
2. A conscientious effort toward good oral hygiene.
3. Recall visits to maintain optimum oral health.
4. Arrangement for the payment of fees at the time of service.

In order for our newly formed relationship to be mutually satisfying and beneficial, we ask that at any time you have a question or are unhappy about any treatment, fee for service, or attitude of our dental team, you will discuss it with us promptly and openly. Misunderstandings and/or lack of communication are the only obstacles to our continued friendship and professional relationship.

Sincerely,

Dr. Jimish Patel

Jimish Patel, DMD
436 Broadway – Village Mall
Methuen, MA 01844

REVIEW OF OFFICE POLICIES

FINANCES

--- A co-payment is collected at the time of service for any restorative work (fillings) for those patients that have dental insurance. Following payment by your insurance, a bill will be sent from our office for the remaining balance.
--- The co-payment for any major work (crown/bridgework, dentures) will be discussed prior to making appointments.
--- We accept Visa, MasterCard, American Express, and Discover. For your convenience, arrangements can be made to keep the credit card information on file to use for your balances.
---For those patients that do not have insurance, payment in full is due at the time of service.
---A Patient Payment Plan is available through CareCredit. This is a convenient, low minimum monthly payment, interest free if paid in full promotional financing option. Ask at the front desk for details.

CONFIRMATION CALLS

Confirmation calls are a courtesy that we extend to our patients. However, we expect our patients to be responsible for remembering scheduled appointments. If you would like, we can send you an email reminder prior to your appointment. If you prefer not to have your appointment confirmed, please let us know.

CANCELLATION POLICY

We understand that appointments may need to be changed or cancelled; however, it is costly to our office if an appointment is missed. If you are unable to keep your scheduled appointment, we ask that you notify our office 24 hours prior to the scheduled time to avoid a missed appointment charge of $50.00.

INSURANCES

---Insurances are billed as a courtesy; patients are responsible for all charges.
---Please follow your insurance guidelines closely. Most dental plans differ. It is your responsibility to understand your plan and to be aware of your co-pays, out-of pocket expenses and yearly maximums.
---Notify us if there is any changes in your insurance, your personal contact information, or your health.

TRANSFERS

If you are transferring from another dental practice, please have your previous records and any recent x-rays forwarded. This will provide us with an accurate baseline of information for future treatment recommendations.

OFFICE HOURS

Our office is opened Monday through Friday. Hours are as follows:

---Monday, Wednesday, and Thursday	8:00 am – 5:00 pm
---Tuesday	1:00 pm – 7:00 pm
---Friday	8:00 am – 1:00 pm

If you need to contact us at other times for dental emergencies, please call the office at (978)682-1002. Leave a message with your name, nature of your call, and a phone number. The answering machine is checked during the hours when the office is not open. A member of our staff will return the call as soon as possible.

We once again welcome you to the practice! If you should have any questions or concerns not outlined here, please do not hesitate to ask.

Patient's Signature_____ Date_____

PATIENT REGISTRATION

NAME_____

HOME ADDRESS_____

CITY_____STATE_____ZIP CODE_____

HOME PHONE #_____CELL PHONE #_____

WORK PHONE #_____E-MAIL _____

PREFERRED METHOD OF CONTACT HOME_____ CELL_____ E-MAIL_____

BIRTH DATE_____SS#_____

REFERRED BY_____

EMERGENCY CONTACT_____PHONE #_____

REASON FOR VISIT_____

EMPLOYER_____

ADDRESS_____

DENTAL INSURANCE_____

SUBSCRIBER'S NAME_____

SUBSCRIBER'S BIRTH DATE _____ID#_____

SECONDARY INSURANCE_____

SUBSCRIBER'S NAME_____

SUBSCRIBER'S BIRTH DATE_____ID#_____

I UNDERSTAND THAT MY INSURANCE IS AN AGREEMENT BETWEEN MY INSURANCE COMPANY AND ME. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR THE BALANCE OF MY DENTAL ACCOUNT REGARDLESS OF MY INSURANCE. INITIAL_____

YES NO YES NO

ARE YOU **ALLERGIC** TO OR HAVE YOU EVER HAD REACTIONS TO ANY OF THE FOLLOWING:

LOCAL ANESTHETICS LIKE NOVOCAINE.....( ).....( )
PENICILLIN OR OTHER ANTIBIOTICS.....( ).....( )
SULFA DRUGS.....( ).....( )
BARBITUATES OR SEDATIVES.....( ).....( )
ASPIRIN.....( ).....( )
IODINE.....( ).....( )
ANY METALS (NICKEL, MERCURY).....( ).....( )
LATEX / RUBBER .....( ).....( )
OTHER_____ ( ).....( )

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

RHEUMATIC FEVER.....( ).....( )
CHEST PAIN.....( ).....( )
HEART DEFECT / MURMUR / ATTACK.....( ).....( )
STROKE.....( ).....( )
MITRAL VALVE PROLAPSE.....( ).....( )
HEART SURGERY.....( ).....( )
PACEMAKER.....( ).....( )
HIGH / LOW BLOOD PRESSURE .....( ).....( )
CONGENITAL HEART PROBLEM .....( ).....( )

FAINTING OR DIZZY SPILLS.....( ).....( )
DIABETES.....( ).....( )
AIDS OR HIV INFECTIONS.....( ).....( )
THYROID PROBLEMS.....( ).....( )
ALLERGIES.....( ).....( )
ARTHRITIS / RHEUMATISM.....( ).....( )
JOINT REPLACEMENT.....( ).....( )
STOMACH ULCER.....( ).....( )
TUBERCULOSIS.....( ).....( )
KIDNEY TROUBLE.....( ).....( )
EPILEPSY OR SEIZURES .....( ).....( )
CHEMOTHERAPY
(CANCER / LEUKEMIA).....( ).....( )
ANEMIA.....( ).....( )
GLAUCOMA.....( ).....( )
TONSILLITIS.....( ).....( )
TUMORS.....( ).....( )
MENTAL HEALTH CARE.....( ).....( )
CHEMICAL DEPENDENCY.....( ).....( )
COLD SORES / FEVER BLISTER .....( ).....( )
ASTHMA OR HAY FEVER .....( ).....( )
HEPATITIS OR LIVER DISEASE .....( ).....( )
SINUS TROUBLE .....( ).....( )

YES NO

DO YOU FEEL PAIN TO ANY OF YOUR TEETH?.....( ).....( )
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? .....( ).....( )
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES? .....( ).....( )
DO YOU HAVE FREQUENT HEADACHES? .....( ).....( )
DO YOU CLENCH OR GRIND YOUR TEETH?.....( ).....( )
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH?.....( ).....( )
HAVE YOU EVER HAD PERIODONTAL TREATMENT ? (GUMS).....( ).....( )
HAVE YOU EVER WORN A BITE PLATE OR OTHER APPLIANCE?.....( ).....( )
HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS?.....( ).....( )

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW :
CLICKING?_____ PAIN (JOINT, EAR, SIDE OF FACE)?_____
DIFFICULTY IN OPENING OR CLOSING?_____DIFFICULTY IN CHEWING?_____

DO YOU WEAR DENTURES OR PARTIALS? _____IF YES, DATE OF PLACEMENT_____

1. ARE YOU IN GOOD HEALTH?_____ Y N

2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR?_____ Y N

3. PHYSICIAN'S NAME_____

ADDRESS_____

PHONE #_____

4. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?_____ Y N

_____

5. ARE YOU TAKING ANY MEDICATIONS? ANY NON-PRESCRIPTION?__ Y N
PLEASE LIST:_____

_____

_____

_____

6. HAVE YOU EVER HAD ANY ABNORMAL BLEEDING?_____ Y N

7. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION?_____ Y N

8. DO YOU USE TOBACCO?_____ Y N

9. ARE YOU WEARING CONTACT LENSES?_____ Y N

10 DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT?_____ Y N

_____

WOMEN ONLY:

ARE YOU PREGNANT? OR THINK YOU MAY BE?_____ Y N
ARE YOU NURSING?_____ Y N
ARE YOU TAKING BIRTH CONTROL?_____ Y N

LAST DENTAL VISIT_____ LAST X-RAYS?_____

SIGNATURE_____ DATE_____

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FINANCIAL & PRIVACY POLICIES

AGREEMENT TO PAYMENT POLICY I acknowledge that I received a copy of financial policy and agree to the terms of payment due.

AUTHORIZATION TO RELEASE INFORMATION I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to Jimish Patel, DMD any and all of my medical record information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

ASSIGNMENT OF BENEFITS I hereby request that payment of authorized insurance benefits be made on my behalf for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENT I agree to pay all applicable charges which are not paid in full by my insurance. If amounts due are not paid according to this financial policy, the account shall be deemed delinquent. In the event that I default on payment of my account, I understand that I am responsible for any and all cost incurred on the collection of my account. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amounts in default. Collection fees will amount to approximately 33% of the balance due.

WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES: I hereby acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practices of Jimish Patel, DMD.

PRINT NAME_____

PATIENT'S SIGNATURE_____**DATE**_____

RESPONSIBLE PARTY_____

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 ___ Other (please specify) 10/11

Jimishkumar Patel, DMD
436 Broadway - Village Mall
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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 ____/____/____, 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, or your location, your general conditions or death. If you are present, then prior to the 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.