



# BOSTON PROSTHODONTICS

## Patient Information

Name:  Mr.  Mrs.  Ms.  Dr. \_\_\_\_\_  Male  Female  
 Single  Married Birthdate: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Mobile phone: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Business phone: \_\_\_\_\_

Business address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Where do you prefer to be contacted?  Home  Cellular  Business  Email

### DENTAL INSURANCE INFORMATION

Name of insured person: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Employer: \_\_\_\_\_ Business phone: \_\_\_\_\_

Business address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Co. name: \_\_\_\_\_ Phone: \_\_\_\_\_ Group #: \_\_\_\_\_

### ADDITIONAL DENTAL INSURANCE INFORMATION

Name of insured person: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Employer: \_\_\_\_\_ Business phone: \_\_\_\_\_

Business address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Co. name: \_\_\_\_\_ Phone: \_\_\_\_\_ Group #: \_\_\_\_\_

### RESPONSIBLE PARTY

Name of person responsible for payment: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**If the person responsible for payment is someone other than the patient, please complete the section below so that we have the appropriate billing information for your account.**

Is the person responsible for payment currently a patient in our office? Yes  No

Home address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Mobile phone: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Business phone: \_\_\_\_\_

Business address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_





# BOSTON PROSTHODONTICS

## Dental History

Patient name: \_\_\_\_\_

What is the reason for your dental visit today? \_\_\_\_\_

Do you currently have any teeth that are sensitive?

Yes  No  If yes, please explain. \_\_\_\_\_

When was the last time you saw a dentist? \_\_\_\_\_

When was your last professional cleaning? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_

How often do you floss your teeth? \_\_\_\_\_

	Yes	No
Have you ever been treated for periodontal disease (gum disease)? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel that you can chew well with your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you grind or clench your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever have jaw pain or jaw muscle soreness? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever worn a nightguard or been told that you should? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you like the way your smile looks? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you like the color of your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any teeth or restorations that you are unhappy with? .....	<input type="checkbox"/>	<input type="checkbox"/>
Would you like to discuss esthetic improvements that can be made to your smile? .....	<input type="checkbox"/>	<input type="checkbox"/>



## Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (“HIPPA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPPA” provides penalties for covered entities that misuse personal health information.

As required by “HIPPA,” we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

- **Treatment** means providing, coordinating or managing healthcare and related services by one or more healthcare providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Healthcare operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

## Notice of Privacy Practices *(continued)*

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information.

For more information about HIPPA  
or to file a complaint:

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independent Avenue, S.W.  
Washington, D.C. 20201  
(202) 619-0257  
Toll free: 1-877-696-6775



## Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# BOSTON PROSTHODONTICS

50 STANIFORD STREET • BOSTON MASSACHUSETTS 02114  
617 523 5451 • WWW.BOSTONPROSTHODONTICS.COM

Welcome to Boston Prosthodontics dental group.

Thank you for choosing us as your dental care provider. We specialize in a full range of dental procedures including Esthetic, Implant, Restorative, and Reconstructive Dentistry. Treatment provided in our office includes professional teeth cleaning, fillings, inlays, onlays, crowns, dental implant crowns, dentures, veneers and teeth whitening.

As trained and certified prosthodontists, we use the most modern and proven techniques and materials. We are committed to excellence and we work closely with our in-house dental laboratory technicians to customize dental esthetics and function for each patient. Our practice philosophy is based on providing all of our patients with the highest quality dental care.

We strive to make your experience here pleasant and we do our best to treat our patients at their reserved appointment times. We ask that you help us fulfill this obligation by arriving on time for your appointments. If you are unable to keep your reserved appointment time, please allow us to treat another patient at that time by notifying the office at least 48 hours in advance prior to your reserved appointment.

We appreciate full payment at the time of service unless prior arrangements have been made with Denise Buckley, our Treatment Coordinator. As a courtesy we file your dental insurance claims for you. You are, however, financially responsible for all services provided to you regardless of your insurance company's coverage for a given procedure.

Please feel free to ask questions about our services or policies. We look forward to helping you optimize and maintain your dental health.

Sincerely,

*Kenneth A. Malament D.D.S., M.Sc.D.*

*Dan Nathanson, D.M.D., M.Sc.D.*

*Samantha King, D.M.D.*

*and Staff*