

GREGORY GUTGSELL & DARREN PHIPPS
Professional Association
P.O. Box 265, New London, NH 03257

PATIENT INFORMATION (CONFIDENTIAL)

Name _____ Date _____
Mailing Address _____
Physical Address _____
Phone Numbers -Home _____ Work _____ Cell _____
Date of Birth _____ Sex M__ F__ Marital Status _____
Name of Spouse _____

ACCOUNT INFORMATION (IF DIFFERENT FROM ABOVE)

Person Financially Responsible for this Account _____
Relationship to Patient _____ Phone # Home _____ Work _____
Mailing Address _____
Physical Address _____

DENTAL INSURANCE INFORMATION

Name of Policy Holder _____ Date of Birth _____
Subscriber Identification # _____ Social Security # _____
Policy Group Number _____ Relationship to Patient _____
Name of Employer _____ Address _____
Name of Insurance Company _____ Phone # _____
Billing Address _____

SECONDARY DENTAL INSURANCE INFORMATION (IF APPLICABLE)

Name of Policy Holder _____ Date of Birth _____
Subscriber Identification # _____ Social Security # _____
Policy Group Number _____ Relationship to Patient _____
Name of Employer _____ Address _____
Name of Insurance Company _____ Phone # _____
Billing Address _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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.

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Do you need to premedicate for dentistry? Yes No
With what medication? _____

Women: Are you
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs

Other If yes, please explain: _____

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed above? Yes No _____

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 _____

FINANCIAL POLICY-GUTGSELL & PHIPPS, DDS, PA

Please return this form signed, with medical history. Thank you!

Welcome to our practice! It is the goal of our practice to maintain the highest of standards and provide you with quality dental care. In order to achieve a mutually satisfying relationship, we are providing you with the following information to avoid any misunderstanding or disagreement concerning payment for professional services.

Payment/co-payment is expected at time of service. Whenever possible, we will estimate fees in advance of your visit. Insurance co-payments will be estimated at the time of your appointment. For your convenience, in addition to cash and checks, we also accept Master Card, Visa, Discover, American Express and Care Credit.

Any extensive treatment that needs to be done should be discussed with the Financial Manager prior to the scheduling of appointments. If you should need to make payments over time, please inquire about Care Credit.

If any account is not paid within 25 days from the date of service, finance charges will be added to the account at a rate of 1.5%/month, for an annual percentage rate of 18%. This is applied to the previous month's balance.

In the case of failure to make payment, any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account, will be added to the account.

Fees quoted by the dental office are only valid for 90 days from the date of the quote.

Your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered under your plan. We are happy to provide the service of submitting your claim, but all payments are ultimately your responsibility.

You may at any time terminate or postpone treatment, understanding that to do so may compromise your dental health.

A fee of \$75.00 will be charged for broken or cancelled appointments. There will be no charge for appointments cancelled with 24 hour notice.
Office hours are 8:00 AM – 5:00 PM, Monday through Friday.

IF YOU HAVE ANY QUESTIONS CONCERNING OUR POLICY, OR NEED ASSISTANCE, PLEASE CONTACT THE FINANCIAL OFFICE. WE ARE HAPPY TO HELP!

Signature: _____ **Date:** _____

Gutgsell, DDS & Darren M. Phipps DDS, PA

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect 04/01/16, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY SEND HEALTH INFORMATION ABOUT YOU

Your protected health information (PHI) includes information relating to your mental or physical health and to the health care provided to you, including materials like your dental records, dental x-rays and payment records. Some documents containing PHI may include such sensitive personal information as a Social Security number, credit card number and other kinds of sensitive information.

Sometimes our dental practice needs to send PHI to the patient or to someone else, such as a specialist. There are various ways to send PHI, including email and other electronic means. Our dental practice regularly uses secure methods for email, unless a patient tells us a message to them does not need to be secure.

There is a risk that unencrypted information may be acquired by hackers or received by unintended recipients. If you are concerned about the security of PHI that may be sent unencrypted, please let us know and we will send it a different way, which may include providing the information to you to deliver.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment and health care operations. For each of these categories, we have provided a description and an example.

Treatment We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, determinations of eligibility and coverage to obtain payment from you, an insurance company or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs and licensing activities.

Individuals Involved in Your Care or Payment for Your Care

We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose

information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief We may use or disclose your health information to assist in disaster relief efforts.

Required by Law We may use or disclose your health information when we are required to do so by law.

Public Health Activities We may disclose your health information for public health activities, including disclosures to:

- prevent or control disease, injury or disability
- report child abuse or neglect
- report reactions to medications or problems with products or devices
- notify a person of a recall, repair or replacement of products or devices
- notify a person who may have been exposed to a disease or condition
- notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence

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 the protected health information of an inmate or patient.

Secretary of HHS We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and credentialing, as necessary for licensure and for the government to monitor the health

care system, government programs and compliance with civil rights laws.

Judicial and Administrative Proceedings If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or by us, to tell you about the request or to obtain an order protecting the information requested.

Research We do not disclose PHI for any research purposes.

Coroners, Medical Examiners and Funeral Directors We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising We do not disclose PHI for any fundraising purposes.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required for disclosure of your PHI for purposes other than those provided for in this notice, or as otherwise permitted or required by law. You may revoke an authorization in writing at any time, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access You have the right to look at, or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. If you request the information that we maintain on paper, we may provide photocopies. If you request the information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a twelve month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with U.S. Department of Health and Human Services.

Our Privacy Official: Gregory P. Gutsell

Contact Officer: Laura Thompson

Office phone number (603) 526-6655 or (603) 526-2424

Fax number (603) 526-6617

P.O. Box 265 New London, NH 03257

laura.gutgsellandphippis@comcast.net

Right to request a restriction You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to notification of a Breach You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice You may receive a paper copy of this Notice upon request, even if you have agreed to receive this notice electronically by email.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in a response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.

Gregory P. Gutsell & Darren M. Phipps, DDS, PA

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgment****

I, _____, have received a copy of this office's Notice of Privacy Practices.
{Print name}

Please list any patients under 21 years of age; _____

{Signature} {Date}

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because;

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgment

An emergency situation prevented us from obtaining acknowledgment

Other (please specify) _____

