Greg S. Solomon, DDS & Associates

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700 Mt Hope Ave Ste 610 • Bangor, ME 04401-5673 (207)945-5952

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____* _____* ____ _____
Last First MI Preferred Name

Title: _____ **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ **Prev. Visit:** _____ **Email Address:**

_____

Phone: _____* _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____* _____*
Address 1 Address 2

_____* _____* _____-_____*
City State Zip Code

Insurance Authorization

I authorize my insurance company to pay the dentist all insurance benefits rendered.

I authorize the use of this electronic signature on all insurance submissions

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance

Consent for Services and Financial Policy

Patients with dental insurance understand that all dental services are charged directly to the insurance company and that he or she is personally responsible for payment of all dental services not covered by their plan, including co-pays, co-insurance and deductibles.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be as billed unless objected to by me, in writing, within the time payment is due. I further agree that failure to pay my billing in a timely manner can result in collection activity and dismissal from the practice.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treament

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I allow this practice to disclose my Protected Health Information to the following individuals: (this information could include: Name, Diagnosis, Test Results, Images, and Account Information.)

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information, (including account information, appointment and clinical information) to the secured web

site for the dental practice. I understand that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of failure to maintain confidentiality.

I understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload, and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information,. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

Consent to Treat

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require a bronchoscopy or other procedures to ensure safe removal.

I understand that I need to disclose to the dentist any prescription drugs that are currently being take or that have been taken in the past, such as Phen-Fen. I understand that taking a class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in the complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the forgoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's Notice of Privacy Practices explaining,

· How this office will use and disclose my protected health information
· My Privacy Rights with regard to my protected health information
· This office's obligations concerning the use and disclosure of my protected health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.

I also understand that if I have any questions or complaints, I may contact:

Greg Solomon, D.D.S
700 Mt. Hope STE 610
Bangor, ME 04401
(207) 945-5952

You may also contact the Secretary of the U.S Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

We made a good-faith effort to obtain an acknowledgement of
Receipt of our Notice of Privacy Practices.

In spite of these efforts, our office has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):
· Patient refused to sign (date of refusal) _____
· Communication barriers prohibited obtaining an acknowledgement.
· An emergency situation prevented us from obtaining an acknowledgement.
· Other _____

Attempt was made by: _____Date:_____

Dental Procedures can create fine water spray or "aerosols" which may remain in the air for several minutes to hours. These aerosols may contain the Covid-19 virus and may create a risk of Covid-19 exposure. You cannot wear a protective mask over your mouth to reduce exposure during treatment as your healthcare providers need access to your mouth to render care. This leaves you vulnerable to transmission while receiving dental treatment.

Covid 19 Pandemic Dental Treatment Notice and Acknowledgement of Risk

The World Health Organization has characterized the Covid-19 Virus, also known as "Coronovirus" as a pandemic. Our practice wants to ensure you are aware of the risks of exposure to Covid-19 associated with receiving treatment during this pandemic.

Covid-19 is highly contagious and has a long incubation period. You and your healthcare providers may have the virus, not show symptoms and yet still be highly contagious. Covid-19 can result in life threatening respiratory disease in some patients. You may be exposed to Covid-19 at any time or in any place. Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental Procedures can create fine water spray or "aerosols" which may remain in the air for several minutes to hours. These aerosols may contain the Covid-19 virus and may create a risk of Covid-19 exposure. You cannot wear a protective mask over your mouth to reduce exposure during treatment as your healthcare providers need access to your mouth to render care. This leaves you vulnerable to transmission while receiving dental treatment.

To provide a safe environment for our patients and staff, this practice follow the applicable state and federal regulations and protocols for infection control, universal personal protection, and disinfection. However, due to the nature of the procedures we provide, it may not be possible to maintain social distancing between patients, doctors, and staff at all times.

I acknowledge that I have read the Notice above and that I understand and accept that there is an increased risk of Covid-19 exposure with treatment during the pandemic.

I understand and accept the increased risk of Covid-19 exposure with treatment at this office.

I also acknowledge that I could, or may have, exposure to Covid-19 from outside this office and unrelated to my visit here.

I have read and understand the information stated above

Signature _____ **Date** _____

Response Date: _____

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Medical History

Patient Name: _____ _____ ___ _____

Last First MI Preferred Name

Date of Birth * _____

Physician Name & Phone number

_____

_____

Approximate Date of last Physical examination _____

Are you under any medical treatment now? * ◯ Yes ◯ No

Are you now taking drugs or medications ? ◯ Yes ◯ No

If Yes, Which Medications?

_____

_____

Have you had any major operations? ◯ Yes ◯ No

If Yes, Which Operations and When?

_____

_____

Have you ever had a serious accident involving head or jaw injuries? ◯ Yes ◯ No

If Yes, When?

_____

_____

Are you allergic to any known materials resulting in - Hives, Asthma, Eczema, etc. ? * ◯ Yes ◯ No

_____

_____

Have you had any adverse responses to any of the following? ◯ Yes ◯ No

☐ Penicillin ☐ Aspirin

☐ Codeine ☐ Other Please List_____

_____

_____

Have you ever had any of the following? * ◯ Yes ◯ No

☐ Heart Ailment/Murmur	☐ Any blood Disease	☐ High Blood Pressure	☐ Any Liver Disease
☐ Low Blood Pressure	☐ Any Kidney Disease	☐ Respiratory Disease	☐ Any Stomach or Intestinal Disease
☐ Thyroid Disease	☐ Any Venereal Disease	☐ Diabetes	☐ Yellow Jaundice or Hepatitis
☐ Rheumatic Fever	☐ Epilepsy	☐ Rheumatism or Arthritis	☐ AIDS or HIV Positive
☐ Tumors or Growths			

Do you have any reason to suspect you are NOT in good health? * ◯ Yes ◯ No

Have you any wounds healed slowly or presenting other complications? * ◯ Yes ◯ No

If Yes, Please Describe

_____

_____

Are you currently pregnant? * ◯ Yes ◯ No

Are you currently on birth control? * ◯ Yes ◯ No

Do you have a history of fainting? * ◯ Yes ◯ No

Have you ever had any X-Ray TREATMENTS (other than diagnostic)? * ◯ Yes ◯ No

Have you received any donor organs, artificial heart valves, vessels, joint implants or use a pacemaker? ◯ Yes ◯ No

If Yes, Please Explain

_____

_____

Do you smoke, use tobacco, or vape? * ◯ Yes ◯ No

Do you have 2 or more alcoholic drinks per day? * ◯ Yes ◯ No

Do you take antibiotic premedication for your dental visits? ◯ Yes ◯ No

If Yes, Please Explain

_____

_____

I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature. *

_____

_____

Signature _____ **Date** _____

Response Date: _____

Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my care).
- Obtaining payment from third party payers (e.g., my insurance company).
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient or Legal Representative Signature

Signature of patient or legal representative | Date

Printed name of legal representative

Relationship to patient

I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.

Signature of patient or legal representative | Date

Staff Confirmation

Name of Staff Member Processing Request (Please Print)

Staff Member Signature

Effective Date

Practice Name

Practice Address

Marketing Authorization Form

Patient Name: _____

Practice Name: _____

Authorizing marketing communications from this practice means I may:

1. Receive communications concerning treatment alternatives or other health related products or services.
2. Be contacted for appointment reminders or information about treatment alternatives or other health related benefits and services that interest me.

I understand I have the right to "opt out" of receiving such communications.

I understand that this practice may receive financial remuneration for communications.

The *Notice of Privacy Practices* used by this practice provides information about communications that are issued for purposes that do not involve financial remuneration.

What this means

Communications that encourage you to use our services are considered marketing. We must **first obtain your written authorization** if we intent to use or sell PHI for personal gain or commercial advantage**.**

Authorization is required for all treatment and health care operations communications where this practice receives financial remuneration for making the communications from a third-party marketing a product or service. This policy ensures that all such communications are treated as marketing communications instead of requiring this practice to have two processes in place based on whether the communication provided to individuals is for a treatment or a health care operations purpose.

We MAY receive financial remuneration from a third party due to marketing. HIPAA states the term *financial remuneration* includes only payments made in exchange for making such communications. Financial remuneration does not include non-financial benefits, such as in-kind benefits, provided to a covered entity in exchange for making a communication about a product or service.

HIPAA also emphasizes that the financial remuneration a covered entity receives from a third party must be for the purpose of communicating on behalf of that third party and that communication must encourage individuals to purchase or use the product or service of the third party. If the financial remuneration received by the covered entity is for any purpose other than for communicating on behalf of that third party, then this marketing provision does not apply.

Marketing Authorization Options:

- ☐ I wish to receive Marketing Communications for this Practice Only.
- ☐ I wish to receive Marketing Communications from this Practice and this Practice's Business Associates.
- ☐ I DO NOT wish to receive ANY Marketing Communications

Patient or Personal Representative Signature _____ Effective Date _____

If Personal Representative - Relationship to Patient _____

Staff Authorization Signature _____ Effective Date _____

Staff Member Name. _____

Staff Member Title _____

Communications Consent Form

Patient Name _____ Date of Birth _____

Home Phone Number _____ Cell Phone _____

Work Phone Number _____ FAX Number _____

E-mail Address _____ FAX Number _____

I give permission to be contacted in the following manner (please fill in phone numbers and check all that apply):

☐ Leave message with information.

☐ Leave message with call-back number only.

☐ Leave message with information.

☐ Leave message at home or on the cell phone with the following individuals: (list name(s) and relationship to patient).

_____
Name of Person to Receive Message

_____
Relationship to Patient

_____
Name of Person to Receive Message

_____
Relationship to Patient

_____
Name of Person to Receive Message

_____
Relationship to Patient

Appointment Reminders

Our office uses an automated appointment reminder system to contact you prior to your scheduled appointment. Please indicate your preference as to how we should contact you:

☐ Home Phone ☐ Cell Phone ☐ Text Message

Written Communication

☐ OK to mail to my home address ☐ OK to mail to my work address

☐ OK to send a FAX ☐ OK to send to email

Communication with Other Healthcare Providers

Patient information or medical records may be communicated to other Healthcare Providers or insurance companies if necessary.

Authorization Signatures

_____ _____

Patient Signature Effective Date

or

_____ _____

Personal Representative Signature Effective Date

_____

Relationship to Patient