EMADENTAL

YOUR SMILE IS OUR PASSION

Welcome to our family of fine patients. The doctors and staff at EMA Dental thank you for selecting us as your personal dental care team. We will strive always to make your relationship with us as pleasant and rewarding as possible.

Responsible, professional dental care relies on providing a firm foundation on which we can base recommendations for your dental health. Therefore, your first visit with us will consist of a thorough initial examination and any necessary x-rays that will aid us in giving you the finest dental care possible. Other diagnostic treatment may be necessary, including models of your mouth and photographs of your teeth and smile. Most importantly, please share with us your dental concerns and requests at this time.

Dental health is not a one-time affair and a plan of preventive dentistry is the most important service we have to offer you. For each patient, we develop a "Dental Health Plan" that is usually presented at a second visit after the doctor has reviewed all of the diagnostic information. Keeping your own natural teeth throughout your lifetime is possible if you desire it, and we will show you how to control your dental destiny.

Concerning our philosophy of treatment, we encourage informative, open discussions, and in doing so, we will listen very carefully so as to determine your concerns, needs, and ultimate treatment desires. Our staff is guided by this philosophy, so please place your confidence in all of us. I am certain you will recognize and appreciate our extra care approach to your dental needs.

Enclosed you will find your patient information sheet and health record form. We ask that you complete these and return them to our office as soon as possible. Your overall health can significantly affect your oral health and a thorough health record allows us to make a more thorough diagnosis. Please bring any recent diagnostic information (i.e., diagnostic casts) to your first appointment. **It is very important that you bring recent x-rays with you to your appointment or have them forwarded prior to your appointment.**

A long-term, mutually satisfying relationship, which gives you the ability to maintain optimum dental health, is what we want for you and your family. Thank you for the confidence you have expressed by selecting us and we are looking forward to seeing you.

Yours in better dental health,

Fran Cavagnac
New Patient Coordinator

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EMIRZIAN, MARIANO & ASSOCIATES

PATIENT REGISTRATION FORM

Date:_____/_____/_____

Patient Information

First Name:_____ Middle Initial:_____ Last Name:_____

Address:_____ Town:_____ State:_____ Zip_____

Home Ph:_____ Work Ph:_____ Cell Ph:_____

Date of Birth: _____/_____/_____ SS #:_____ Email :_____

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

Employment Status: O Full Time O Part Time O Retired Student Status: O Full Time O Part Time

Referred By:_____ Previous Dentist:_____ Last Seen:_____

Responsible Party (if someone other than patient)

First Name:_____ Middle Initial:_____ Last Name:_____

Address:_____ Town:_____ State:_____ Zip_____

Home Ph:_____ Work Ph:_____ Cell Ph:_____

Date of Birth: _____/_____/_____ SS #:_____ Email :_____

Primary Insurance Information

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

Insured Date of Birth: _____/_____/_____ Insurance ID # or Social Security #:_____

Insurance Carrier:_____ Address:_____

Employer's Name:_____ Address:_____

Secondary Insurance Information (if applicable)

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

Insured Date of Birth: _____/_____/_____ Insurance ID # or Social Security #:_____

Insurance Carrier:_____ Address:_____

Employer's Name:_____ Address:_____

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MEDICAL HISTORY

Name:_____ DOB:_____/_____/_____ 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 _____
Are you on a special diet? ◯ Yes ◯ No _____
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

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 ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ 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 _____

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Dental History

Name: _____ Date:_____/_____/_____

Do you need to premedicate for dental appointments (circle): Yes No

If yes, what type of antibiotic have you historically used (i.e. amoxicillin, etc)? _____

Do you …	**Yes**	**No**
1. Have teeth sensitivity to hot, cold or pressure?	_____	_____
2. Have bleeding gums?	_____	_____
3. Experience food catching between your teeth?	_____	_____
4. Have spaces developing between your teeth?	_____	_____
5. Clench or grind your teeth?	_____	_____
6. Experience jaw cracking, popping, or discomfort when you when you open or close your mouth?	_____	_____
7. Have a history of orthodontic treatment (braces)?	_____	_____
8. Have a history of any periodontal (gum) treatment?	_____	_____
9. Have a history of unfavorable dental experiences?	_____	_____
10. Have concerns about the appearance of your teeth?	_____	_____
11. Like the color of your teeth?	_____	_____
12. Have the desire to change the appearance of your teeth if you could?	_____	_____
13. Have old fillings or previous dental treatment that is no longer satisfactory to you?	_____	_____
14. Experience discomfort when biting or chewing?	_____	_____
15. Snore?	_____	_____

What type of dental homecare products do you use? _____

Please tell us about any other problems, concerns or questions that you would like to have addressed. We will do our best to listen attentively to your concerns so we can present you with the best possible treatment options.

_____

_____

_____

When was your last…

dental exam _____/_____/_____ last dental cleaning _____/_____/_____

bitewing xrays* _____/_____/_____ full mouth series of xrays* _____/_____/_____

panoramic xray* _____/_____/_____

*it will be of utmost importance to know when your last dental xrays were taken, if unsure please call your previous dental health provider to inquire. To avoid need for additional xrays to be taken and associated charges incurred, please make sure to bring recent xrays with you. Bitewings are considered recent if less than 1 year old, full mouth series and panoramic xrays are considered recent if less than 5 years old.

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DENTAL INSURANCE INFORMATION & FINANCIAL ARRANGEMENT POLICIES

DENTAL INSURANCE

We strongly feel that our patients deserve the very best possible dental care we can provide. In an effort to maintain this high quality of care, we would like to share with you some facts about DENTAL INSURANCE.

There are literally hundreds of plans, each one different, depending on the amount you and/or your employer are contributing to them. Most dental insurance plans, at this time, are group plans and most cover between 30 and 80 percent of costs for restorative treatment and up to 100% for preventative maintenance, most often up to a yearly maximum of between $500 and $2000.

Since most insurance carriers base their benefits on a schedule of allowances that are below the usual and customary fees of the area, they usually pay only a portion of your investment. We urge you to be fully aware of the provisions of your dental plan.

If you would like to know what your insurance benefits will be before you begin treatment, we urge you to contact your carrier directly.

Please be assured that our office will do our very best to assist you in maximizing the insurance benefits for your dental treatment. We invite you to call or come in and talk with us if you have any questions relating to your insurance or proposed treatment.

AVAILABLE DENTAL PAYMENT OPTIONS

1. For routine services, payment is due at the time treatment is rendered.

2. For treatment over $500.00, we offer a bookkeeping courtesy of 3 percent of the total fee when payment is made in full with cash or check prior to your appointment.

3. For more complex restorative treatment (crowns, bridgework, dentures, implants, etc...) an initial payment of one-half of the total fee will be required at the beginning of treatment and the balance is due prior to placement of final restoration. Special arrangements may be made upon request.

4. Credit Cards: We accept MasterCard, Visa and Discover, as well as various specialized health/dental financing credit programs including Care Credit & Springstone Patient Financing, who often offer financing rates as low as 0%. Ask for details.

5. Dental Insurance Plans: Our professional services are rendered to you, the patient, and we feel it is important that financial arrangements be made directly with you. For your convenience our office will submit your insurance claim electronically for your reimbursement. Insurance payments will be paid ***directly to you*** by your insurance carrier.

DIAGNOSTIC FEE SCHEDULE

To help you prepare for your first visit, we are providing a diagnostic fee schedule. While all diagnostic services may not be needed, we are providing the information as a courtesy. Please keep in mind that if you are able to provide current radiographs from another office, it may keep us from having to retake the radiographs and will, in turn, save you the cost of the service.

Comprehensive Examination and Dental Health Planning ...	$145
Consultation, 2nd Opinion …	$125-$225
Full Series Radiographs …	$175
Panoramic Radiographs …	$168
Diagnostic Casts …	$94
Diagnostic Photos …	$76
Dental 3-D CT Scan …	$375

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NOTICE OF PRIVACY PRACTICES
Effective date of notice: _____/_____/_____

16 Gerrard Avenue
E Longmeadow, MA 01028

64 Gothic Street
Northampton, MA 01060

Contact: Colleen Nadeau, Administrator

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;

•disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

•ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
•ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
•ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
•ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
•get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

•get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

---------- tear here ----------

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of EMA Dental's Notice of Privacy Practices.

Patient name: _____ Patient's Date of Birth: _____/_____/_____

Signature: _____ Date: _____/_____/_____

EMADENTAL
EMIRZIAN, MARIANO & ASSOCIATES

Appointment Cancellation and No-Show Agreement

At EMA Dental, our goal is to provide personalized, quality dental care to each of our patients in a timely manner. Our appointment cancellation and no-show agreement was developed to allow us to better utilize available appointments for our patients in need of care.

Appointment Cancellation

- We reserve appointment times specifically for each patient so that we may provide services of the highest caliber.

- Please schedule carefully and if you must reschedule, please notify us with **at least 48 hours notice to avoid a charge to your account.** Sufficient notice allows us to contact patients who are on a waiting list for last-minute appointments. To cancel or reschedule an appointment, please call during **normal business hours to speak with a member of our staff personally.**

Late Arrivals/Last Minute Cancellations/No-Shows

- Late arrivals can create scheduling issues for other patients. Please notify us as soon as possible if you anticipate arriving late for your appointment so that we can confirm that we will be able to accommodate you.

- No-shows and last-minute cancellations prevent us from offering our services to other patients in need and as such, a nominal fee will be assessed if the above cancellation guidelines are not adhered to.

- Failure to present to an appointment without providing notice or providing last-minute notice will be recorded accordingly in your chart.
    - Two ***consecutive*** no-shows or last-minute cancellations will result in being administratively discharged from our care.
    - Three recorded no-shows or last-minute cancellations will result in being administratively discharged from our care.
    - You will be notified in writing in the event of an administrative discharge.

Your understanding and cooperation is appreciated. If you have any questions regarding this agreement, please let our staff know so that we can clarify any of the information provided.

I, the undersigned, have read and understand this Appointment Cancellation and No-Show Agreement. I agree to the stated terms.

_____ _____/_____/_____

Patient Signature (Guardian if Patient is a Minor) Date

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EMIRZIAN, MARIANO & ASSOCIATES

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name: _____

Patient Address: _____

Patient Phone Number: _____

I authorize my previous dental care provider (whose information is below) to release my dental x-rays/records or copies of such to EMA Dental:

Name of Previous Doctor or Practice:_____

Address:_____

City:_____ State:_____ Zip:_____

_____ ___/___/___

Signature of Patient or Legal Guardian Date

Please email records to lisal@emadental.com or mail hard copies to:

EMA Dental
16 Gerrard Avenue
E Longmeadow, MA 01028