PATIENT REGISTRATION

ID: ____________ Chart ID: ____________

First Name: ____________ Last Name: ____________ Middle Initial: ______

Patient is: ☐ Policy Holder ☐ Responsible Party Preferred Name: ____________

Responsible Party (if someone other than the patient)

First Name: ____________ Last Name: ____________ Middle Initial: ______

Address: ____________ Address 2: ____________

City, State, Zip: ____________ Pager: ____________

Home Phone: ____________ Work Phone: ____________ Ext: ______ Cell Phone: ____________

Birth Date: ____________ Social Security: ____________ Drivers License: ____________

☐ Responsible Party is Policy Holder for Patient ☐ Primary Policy Holder ☐ Secondary Policy Holder

Patient Information

Address: ____________ Address 2: ____________

City, State, Zip: ____________ Pager: ____________

Home Phone: ____________ Work Phone: ____________ Ext: ______ Cell Phone: ____________

Sex: ☐ Female ☐ MaleMarital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: ____________ Age: ______ Social Security: ____________ Drivers License: ____________

E-mail: ____________ ☐ I would like to receive email correspondences via e-mail

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: ____________ Pref. Dentist: ____________

Employee ID: ____________ Pref. Pharmacy: ____________

Carrier ID: ____________ Pref. Hygienist: ____________

Section 3

Employer: ____________

____

____

____

____

Dental

Last Cleaning ____________ Problem Areas ____________ Former Dentist & Dental Office

Last X-Rays ____________ ____________ ____________

Primary Insurance Information

Name of Insured: ____________ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security: ____________ Insured Birth Date: ____________

Employer: ____________

Address: ____________

Address 2: ____________

City, State, Zip: ____________

Insurance Company: ____________

Address: ____________

Address 2: ____________

City, State, Zip: ____________

Rem. Benefits: ____________ Rem. Deduct: ____________

Secondary Insurance Information

Name of Insured: ____________ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security: ____________ Insured Birth Date: ____________

Employer: ____________

Address: ____________

Address 2: ____________

City, State, Zip: ____________

Insurance Company: ____________

Address: ____________

Address 2: ____________

City, State, Zip: ____________

Rem. Benefits: ____________ Rem. Deduct: ____________

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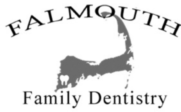
FALMOUTH FAMILY DENTISTRY



Date Created ______________________________

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
If yes, please explain: ______________________

Have you ever taken, Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No
If yes, please explain: ______________________

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No
If yes, please explain: ______________________

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 ☐ Sulpha Drugs ☐ Local Anesthetics ☐ Other

If yes, please explain: ______________________

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

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

X ____________________ Date: ____________

FALMOUTH FAMILY DENTISTRY

DENTAL HISTORY FORM

General Information

Patient Name ______________________________

Patient Birth Date ______________________________

Do you wear contact lenses?	No	Yes
Are you currently taking diet pills?	No	Yes
Do you use tobacco products?	No	Yes

If yes, how frequently? ______________________________

For Women

Are you currently taking birth control pills?	No	Yes
Are you or do you think you may be pregnant?	No	Yes
If yes, Due Date ________ Are you nursing?	No	Yes

Dental History

Date of last dental exam ______________________________

What treatments were performed during your last appointment?

____

Previous Dentist ______________________________

May we request previous dental records? No Yes

Are you currently experiencing pain or discomfort in or near your: Ears Jaw Mouth Neck

If yes, please describe ______________________________

Office Use Only (for future appointments)

Any changes in the patient health since the last office visit?	No	Yes

If yes, please describe ______________________________

Any new medications?	No	Yes

If yes, please list ______________________________

____

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Falmouth Family Dentistry
337 Gifford Street   Falmouth, MA 02540
Phone (508) 548-2999   Fax (508) 548-9845

Patient Compliance Office Policy

I understand after being treated for my dental procedure, I will continue to maintain myself as an active patient of record by following the Patient Compliance Office Policy.

I will complete my routine hygiene visits including necessary periodontal cleanings, radiographs and periodontal charting before I can be seen for future treatment including emergencies.

I agree, if I do not maintain my periodontal appointments consistently during the year, I will become an inactive patient of record and I will no longer be able to be treated for dental emergencies in the future.

Patient Name ____

Signature ____________________________________ Date ______________

Thank You
J. & C. Gagnon, D.M.D., P.C.

New Wave Printing & Design, Inc. 7/2020

Financial and Cancellation Policy

Thank you for choosing Falmouth Family Dentistry as your dental health care provider. We believe that all of our patients deserve the very best dental care we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. Please understand that payment of your bill is considered a part of treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE
We accept cash, checks and most major credit or debit cards. We request all copayments, deductibles and any service not covered by your insurance plan be paid at the time the service is rendered.

Regarding Insurance
Our dental professionals will diagnose and recommend treatment regarding your dental health and personal dental concerns based on their professional judgement. Dental insurance is a benefit designed to help defray the cost of quality dental care, but is not all-inclusive of what an individual may need or desire to obtain optimal dental health for a lifetime. It is for that reason, insurance coverage should not be considered the standard on which you determine what is appropriate for your dental health needs.

Furthermore, dental insurance is a contractual agreement between you, your employer, and the insurance company. Our office is not part of that contract. We bill your insurance company as a courtesy and collect your estimated portion at the time services are provided. Also, be aware that although we may be able to estimate your portion, we cannot guarantee any out of pocket expense. Ultimately, **you** are responsible for payment; regardless of any insurance company's arbitrary determination of usual and customary rates.

****If you have insurance that our providers are out of network with, you will be responsible for payment **IN FULL at the time of service**. We will be happy to submit the dental claim to your insurance company on your behalf, and have them reimburse you directly.

Our Fees
Our fees are based on the quality of materials we use and the time, effort and skill required by our dental professionals in performing your needed treatment.

Past Due Accounts
After a period of **60** days of non-payment by an insurer, the entire bill becomes the responsibility of the patient.
After **90** days of non-payment, we reserve the right to take necessary steps to collect this debt which may include a collection agency. Checks that are returned to our office from your financial institution are subject to a $25.00 non-refundable returned check fee.

CANCELLATION POLICY
We are committed to seeing our patients on time and respecting their time. Same day cancellations (less than 24 hours' notice), failed appointments and late arrivals are disruptive to our schedule and other patients. In order to maintain our schedule, we request 48 hours notice for cancellations or rescheduling of appointments. In the instance of a same day cancellation or failed appointment, there may be a charge of $40.00. Repeated same day cancellations or missed appointments will result in the patient being dismissed from the practice.

Signed Acknowledgement
I understand that any insurance coverage estimate given to me by the office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself and my dependents in this dental office. I have received, read, and agree to the financial and cancellation policies listed above.

____

Patient, Parent or Guardian Signature   Date

____

Patient Name (Please Print)

New Wave Printing & Design, Inc. 7/2020

FALMOUTH Family Dentistry

General Dental Informed Consent Form

The Doctors would like all of their patients to have knowledge of risks and benefits of dental procedures. We ask that you review the procedures listed and feel free to ask any questions. A treatment plan for all restorative work, which includes **estimated fees** and treatment specific authorization, will be presented to you for your review and signature at the time treatment is recommended.

1. Drugs and Medication: Antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction.) Risk of local anesthesia may include temporary or permanent numbness or bruising.

2. Changes in Treatment: During treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures.

3. Removal of Teeth: Alternatives will be explained to you (root canal therapy, crowns, and periodontal surgery, etc.) The removal of teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. Some of the risks are pain, swelling, spread of infection, dry socket, loss of feeling in teeth, lips, tongue, and surrounding tissue (paresthesia) that can last for an indefinite period (days or months) or fractured jaw. Further treatment by a specialist or even hospitalization if complications arise during or following treatment would be your responsibility.

4. Crowns and Bridges: Sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. You may wear temporary crowns, which may come off. You will need to be careful to ensure that they are kept on until the permanent crowns are delivered. The final opportunity to make changes to a new crown, or bridge (including shape, fit, size, or color) must be done at the preparation appointment.

5. Partials: They are artificial, constructed of plastic, metal and/or porcelain. The problem of wearing these appliances, including looseness, soreness, and possible breakage. Most partials require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial fee.

6. Endodontic Treatment (Root Canal): There is no guarantee that root canal treatment will save a tooth. Complications can occur from the treatment. Occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

7. Periodontal Loss (Tissue & Bone): This is a serious condition, causing gum and bone infection and can lead to the loss of teeth. Alternative treatment will be explained to you (gum surgery, replacements, and/or extractions). Any dental procedure may have a future adverse effect on your periodontal condition.

8. Implants: Are permanent alternatives to bridges, partials, or dentures. This process involves the participation of an oral surgeon or periodontist. Fees for his/her services are separate from our service fees. This process involves several steps and could last from 2-6 months before completion (depending on healing time needed). As with crowns, color may not match perfectly with natural teeth.

9. Sealants: There is no guarantee that a sealant will prevent all cavities. They do, however, form a hard shield that keeps food and bacteria from getting into tiny grooves and causing decay along the chewing surfaces of the back teeth. Occasionally sealants need to be replaced, since they do not last a lifetime. We do, however, warranty our sealants for 2 years if the patient is seen twice a year for prophylaxis visits. Sealants can be done at any age if the teeth are free of decay and fillings. The doctor will determine the best time to have them done.

10. Sedative Fillings: Sedative fillings are temporary. They are placed if decay is near the nerve. If the tooth becomes symptomatic after 4-6 weeks, it's likely the tooth will need a root canal or it may need to be extracted. If the tooth is asymptomatic after 4-6 weeks, then the treatment can be continued. The sedative filling allows the tooth to lay down reparative dentin and may enable the Doctor to restore the tooth.

Treatment Risk: I understand that any time a restoration is performed there is a possibility of trauma to the nerve of the tooth, which could result in varying degrees of sensitivity and complications including but not limited to the following: cold sensitivity, hot sensitivity, biting sensitivity, abscess, pulp necrosis. Most of the symptoms usually resolve as the nerve heals. Complications may arise resulting in the need for additional treatment. This may include one or more bite adjustments, replacement of the restoration due to open margins discovered after final cementation, root canal treatment or tooth removal. I have carefully read above conformed consent and fully understand all risks as it relates to my case.

Patient (Guardian) Signature ______________________________ ***Date*** ______________

New Wave Printing & Design, Inc. 7/2020

Effective date of notice: October 01, 2016

NOTICE OF PRIVACY PRACTICES

J & C GAGNON, D.M.D.
FALMOUTH FAMILY DENTISTRY
337 Gifford St. Falmouth, MA 02540
508-548-2999

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; refering 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.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

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; notices to and from the federal Food and Drug Administration regarding or medical devices;
- 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 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 of friends who are helping your 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 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. Sending 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 and 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 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 to 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.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the Notice of Privacy Practices.

Effective Date of Notice: October 1, 2016

NOTICE OF PRIVACY PRACTICES

J. & C. Gagnon, D.M.D.

Falmouth Family Dentistry

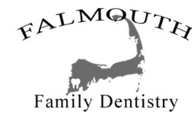
ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have read a copy of J & C Gagnon D.M.D. Notice of Privacy Practices.

Patient Name ____

Signature ____________________________________ Date ________________

Falmouth Family Dentistry
337 Gifford Street Falmouth, MA 02540
Phone (508) 548-2999 Fax (508) 548-9845



REQUEST FOR AND RELEASE OF PROTECTED DENTAL INFORMATION

Patient Name ______________________________ DOB ______________

Mailing Address ____

Home Phone ______________ Work Phone ______________ Cell Phone ______________

I authorize *Falmouth Family Dentistry* to release and discuss information pertaining to my identity, prognosis, diagnosis or treatment.

**Note:* Release of Information must comply with the federal HIPAA Privacy Act and Federal Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR, part 2 regulations.

**Note to recipient:* This contains confidential information. 42 CFR part 2 prohibits you from making any further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information Is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that by law, I do not need to consent to the release of/request for this information to receive care or payment for care or to be eligible for enrollment or any benefits. However, I choose to do so willingly and voluntarily for the purpose specified above. My signature acknowledges my receipt and understanding of *Falmouth Family Dentistry* Notice of Privacy Practices. I understand that I have a right to receive a copy of this form after I have signed it. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by confidentiality rules.

I understand that I may revoke this authorization in writing. Upon revocation, information will not be released except to the extent that we have already taken action in response to this authorization. I also release Falmouth Family Dentistry from all legal responsibilities and liabilities that may arise from the release of the information.

Signature of Patient ______________________________ Date ______________

Signature of Patient/Personal Representative ______________________ Date ______________

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