Connolly
FAMILY DENTISTRY

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ M____ Sex: ○ M ○ F

BIRTHDATE _____ AGE_____ Soc. Sec. #_____ Parent's/Guardian's Name _____

RESIDENCE Street _____ Apt. # _____ City _____ State_____ Zip_____

MAILING (If different from above) Street_____Apt. #_____ City_____ ST_____ Zip_____

HOME PHONE_____ CELL PHONE_____WORK PHONE_____

E-MAIL_____ I would like to receive text message appointment reminders ○ YES ○ NO

EMERGENCY CONTACT Name_____ Relationship_____ Contact #_____

Who May We Thank for Referring You To Our Office? _____Reason For This Visit _____

INSURANCE INFORMATION (PRIMARY)

POLICY HOLDER NAME Last _____ First _____ M_____ BIRTHDATE_____

Soc. Sec. #_____ (Most insurances require this for eligibility – Do **NOT** leave blank) OCCUPATION_____

Employer _____ Insurance Company_____

Insurance Company Address_____

Group #_____ Member ID #_____ (This could be Policy Holder's SS#) Local#_____

INSURANCE INFORMATION (SECONDARY)

POLICY HOLDER NAME Last _____ First _____ M_____ BIRTHDATE_____

Soc. Sec. #_____ (Most insurances require this for eligibility – Do **NOT** leave blank) OCCUPATION_____

Employer _____ Insurance Company_____

Insurance Company Address_____

Group #_____ Member ID #_____ (This could be Policy Holder's SS#) Local#_____

PATIENT NAME (PRINT) DATE OF BIRTH

Connolly
FAMILY DENTISTRY

Patient Medical History

Physician_____ Physician Address_____Physician Phone_____

Are you under a phsyicians care now? ___ Yes ___No If yes, please explain: _____

Are you taking any medications or prescriptions? ___Yes ___No Please list medicines:_____

_____

_____

Do you take or have you taken Fen-Phen/Redux? ___Yes ___No

Have you taken any medications containing bisphosphonates? ___Yes ___No

Do you use tobacco? (ie. Cigars, chew, and cigarettes) ___Yes ___No How long? _____

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 ___Advil/NSAIDS

___ Metal ___Latex ___ Sulfa Drugs ___Erythromycin ___Nitrous Oxide

Other (please list):_____

Please indicate of the following which you have had or presently have:

AIDS/HIV Positive	YES	NO	Emphysema	YES	NO	Low Blood Pressure	YES	NO
Alzheimer's Disease	YES	NO	Epilepsy or Seizures	YES	NO	Lung Disease	YES	NO
Anaphylaxis	YES	NO	Fainting Spells/Dizziness	YES	NO	Mitral Valve Prolapse	YES	NO
Anemia	YES	NO	Frequent Headaches	YES	NO	Osteoporosis	YES	NO
Angina	YES	NO	Glaucoma	YES	NO	Psychiatric Care	YES	NO
Arthritis/Gout	YES	NO	Heart Attack/Failure	YES	NO	Radiation Treatments	YES	NO
Artificial Heart Valve	YES	NO	Heart Murmur	YES	NO	Reflux/G.E.R.D.	YES	NO
Artificial Joint	YES	NO	Heart Pacemaker	YES	NO	Respiratory Issues	YES	NO
Asthma	YES	NO	Heart Disease	YES	NO	Rheumatic/Scarlet Fever	YES	NO
Blood Disease	YES	NO	Hepatitis A	YES	NO	Shingles	YES	NO
Blood Transfusion	YES	NO	Hepatitis B or C	YES	NO	Shortness of Breath	YES	NO
Cancer	YES	NO	Hemophilia	YES	NO	Sickle Cell Disease	YES	NO
Chemotherapy	YES	NO	Herpes	YES	NO	Sinus Issues	YES	NO
Chest Pains	YES	NO	High Blood Pressure	YES	NO	Spina Bifida	YES	NO
Circulatory Problems	YES	NO	High Cholesterol	YES	NO	Stroke	YES	NO
Cold Sores/Fever Blisters	YES	NO	Irregular Heartbeat	YES	NO	Swelling of Limbs	YES	NO
Congenital Heart Disorder	YES	NO	Kidney Problems	YES	NO	Tonsillitis	YES	NO
Diabetes	YES	NO	Leukemia	YES	NO	Ulcer/Colitis	YES	NO
Drug Addiction	YES	NO	Liver Disease	YES	NO	Venereal Disease	YES	NO

PATIENT NAME (PRINT) DATE OF BIRTH

Connolly
FAMILY DENTISTRY

PATIENT DENTAL HISTORY

How long since you have seen a dentist? _____ Last cleaning?_____ Last Full Mouth X-Rays?_____

Are you having problems now, please explain?_____

Is your present dental health poor?	YES	NO	Are your teeth sensitive to sweets/sours?	YES	NO
Do you wear dentures?	YES	NO	Are your teeth sensitive to pressure?	YES	NO
Are you happy with your dentures?	YES	NO	Do you have headaches, earaches, or neck pains?	YES	NO
Would you like to know more about permanent replacements?	YES	NO	Do you have discolored teeth that bother you?	YES	NO
Have you had any periodontal (GUM) treatments?	YES	NO	Are you unhappy with the appearance of your teeth?	YES	NO
Do your gums bleed, feel tender, or irritated?	YES	NO	Have you worn braces on your teeth (orthodontics)?	YES	NO
Are you aware of grinding or clenching your teeth?	YES	NO	Would you like your smile to look better or different?	YES	NO
Are your teeth sensitive to hot/cold?	YES	NO	Do you regularly use dental floss?	YES	NO

Rate your level of anxiety from 1-5 (five being the highest): ____

Rate your level of concern for dental cost from 1-5 (five being the highest): _____

Do you have any other concerns or information you would like the doctor to be aware of?:_____

_____

_____

Patient Name Patient Signature Date

PATIENT NAME (PRINT) DATE OF BIRTH

Connolly
FAMILY DENTISTRY

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I acknowledge that I have been provided a copy of Christopher J. Connolly, DMD, PA's Notice of Privacy Practices, which has an effective date of 06/01/2018, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.
Initial Below

x_____ I hereby give my consent for Christopher J. Connolly, DMD, PA to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Christopher J. Connolly, DMD, PA describes such uses and disclosures more completely.)

x_____ With this consent, Christopher J. Connolly, DMD, PA may call my home or other alternative location and leave a message on voice mail, ***text message***, or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, payments and any calls pertaining to my clinical care and treatment.

x_____ With this consent, Christopher J. Connolly, DMD, PA may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

x_____ With this consent, Christopher J. Connolly, DMD, PA may ***e-mail*** to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.
With this consent, I grant Christopher J. Connolly, DMD, PA permission to share my PHI (as outlined above) with

_____ Relationship to patient: _____

_____Relationship to patient: _____

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices.
By signing this form, I am consenting to allow Christopher J. Connolly, DMD, PA to use and disclose my PHI to carry out TPO.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Christopher J. Connolly, DMD, PA may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's or Legal Guardian's Name Date

PATIENT NAME (PRINT) DATE OF BIRTH

Connolly
FAMILY DENTISTRY

Financial Policies

We are so pleased that you have chosen Christopher J. Connolly, DMD, PA to take care of all of your dental healthcare needs and we are thrilled to welcome you to our practice. We will do our best to ensure that you receive excellent, comprehensive care at our facility. All of our practitioners and staff members pride themselves on the longstanding, positive relationships we create with our patients. For that reason, and to prevent any future misunderstandings, please review our office's Financial Policies. We thank you for understanding and for cooperating with the following policies. **Please initial where indicated and sign below**.

FINANCIAL RESPONSIBILITY:

x_____ The undersigned agrees, whether signing as the patient or as an agent of the patient, that in consideration of the services rendered to the patient, he/she is responsible for all or any unpaid portion of the bill incurred. This includes but is not limited to: deductibles, copayments, or the entire bill if denied by insurance or if uninsured.

x_____ Christopher J. Connolly, DMD, PA expects that payment is made on or before the date that services were rendered. We accept cash, check*, Visa/Mastercard/Discover and Care Credit.

*Existing patients or patients of record ONLY

RETURNED CHECKS:

x_____ If any checks are returned by the bank, we require that the amount be immediately reimbursed by cash or credit. In addition to the original payment, you will be responsible to pay the $20.00 bank service charge assessed to our practice for returned checks.

CANCELLATION POLICY:

x_____ We ask 24 hours advance notice for cancelling or rescheduling an appointment. If appointments are broken in less than 24 hours, you may be assessed a $50 cancelation fee. All cancellation fees MUST be paid in full prior to scheduling any other appointments.

The treatment that is planned for you is specific to you and your health. It is important for you to keep your scheduled appointments to properly complete your treatment and restore your overall wellness. A broken appointment is a loss to three people—you, the patient who missed the valuable time with one of our practitioners; a patient waiting for an appointment who would've taken the appointment had they had more notice; and the doctor who was fully staffed and prepared for visit.

I have read and understand my responsibilities according to Christopher J. Connolly, DMD, PA's Financial Policies.

_____

Patient/Guardian/Agent's Signature Date

Please print Patient/Guardian/Agent's Name: _____

PATIENT NAME (PRINT) DATE OF BIRTH

Christopher J. Connolly, DMD, PA
379 Egg Harbor Road, Sewell, NJ 08080
856-582-0090

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

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

HIPAA provides penalties for covered entities, including our Practice, that misuse "protected health information" (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to your PHI. We also have legal obligations to notify you in the event of a breach of unsecured PHI.

This Notice of Privacy Practices describes how we may use and disclose your PHI for treatment, payment, healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. This Notice of Privacy Policies takes effect on 06/01/2018, and remains in effect until we replace it. We are required to abide by the terms of the Notice of Privacy Practices that is in effect.

We reserve the right to change our privacy practices and the terms of this Notice of Privacy Practices at any time, provided such changes are permitted by applicable law. We reserve the right to make any changes in our privacy practices effective for all PHI that we maintain, including health information we created or received before we made the changes. In the event of a change in our practices, we will provide you with a copy of the revised Notice of Privacy Practices through one or more of the following methods: posting the Notice of Privacy Practices to our website, mailing you a copy, or providing you a copy at your next appointment with us.

You may request a copy of our current Notice of Privacy Practices at any time. For more information about our practices, or for additional copies, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Treatment: We may use or disclose your PHI to personnel in our office, as well as to physicians and other healthcare professionals within or outside our office, who are involved in your medical care and need the information to provide you with medical care and related services. For example, we may use or disclose your PHI in consultations and/or discussions regarding your medical care and related services with healthcare providers who we refer to and receive referrals from. We require authorization to disclose your PHI to healthcare providers not currently involved in your care.

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. If you personally pay in full for service(s), you have the right to restrict us from disclosing your PHI with respect to that service(s) to your health plan/insurer. For example, we may give your health insurance provider information about you so that they will pay for your treatment.

PATIENT NAME (PRINT) DATE OF BIRTH

Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, and credentialing activities. For example, we may disclose PHI to medical students who are performing work with our office or call your name in the reception area.

Appointment Reminders and Other Contacts: We may disclose PHI in the course of leaving phone messages and in providing you with appointment reminders via phone messages, postcards, or letters. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates: We may disclose PHI to our business associates, such as billing services or healthcare professionals providing services as independent contractors, for the purpose of performing specified functions on our behalf and/or providing us with services. PHI will only be used or disclosed if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of PHI and are not allowed to use or disclose any PHI other than as specified in our contract with them.

Your Family, Friends, and Representatives: We may use or disclose PHI to notify or assist in the notification of a family member, domestic partner, close personal friend, your personal representative, an entity assisting in a disaster relief effort, or another person responsible for or involved in your care. If you are present, prior to use or disclosure of PHI we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity, your death, or in emergency circumstances, if deemed appropriate based upon our professional judgment, we will disclose PHI that is directly relevant to the person's involvement in your care. We may inform such person(s) of your location, your general condition, or death. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to obtain prescriptions, medical supplies, x-rays, or other similar forms of PHI on your behalf. We will not disclose PHI to such an individual if doing so would be inconsistent with any of your prior wishes that are known by us.

Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Coroners, Medical Examiners and Funeral Directors: We may release PHI to coroners or medical examiners as necessary, for such purposes as identifying a deceased person or determining the cause of death. We also may release PHI to funeral directors as necessary for their duties.

National Security: Under certain circumstances, we may disclose PHI to military authorities. We may disclose PHI to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities. Under certain circumstances, we may disclose PHI to a correctional institution or law enforcement official with whom you are in lawful custody.

Fundraising: We may contact you in relation to fundraising activities, however you have the right to opt out of receiving such communications.

Data Breach Notification Purposes: We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Required by Law: We may use or disclose your PHI when we are required to do so by law. Such circumstances include, but are not limited to, compliance with a court order, mandatory reporting due to serious or imminent threats to the public, mandatory reporting of child abuse or neglect, in response to government agency audits or investigations, and reporting disclosures to the Secretary of the Department of Health and Human Services as necessary for the purpose of investigating or determining our compliance with HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH) rules.

YOU MAY PROVIDE ADDITIONAL AUTHORIZATION

PATIENT NAME (PRINT) DATE OF BIRTH

Marketing Uses: We may only use or disclose your PHI for marketing purposes if you authorize us to do so. Such authorization would allow us to disclose PHI to a third party vendor business associate for the purpose of providing you with targeted supplementary products or services when your physician believes such offerings will be of value to you. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

Sale: We may only use or disclose your PHI in a manner that constitutes a sale of information if you authorize us to do so. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

To Others Upon Your Specific Authorization: In addition to our use of PHI as described in this Notice of Privacy Practices, you may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures

permitted by your authorization while it was in effect. If the Practice maintains any psychotherapy notes, they will not be released unless you sign an authorization or if otherwise required by law. Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose your genetic information to insurance providers or others for underwriting purposes.

PATIENT RIGHTS

Access: You have the right to inspect and receive copies of your PHI, or to receive your PHI electronically, with limited exceptions. You may also request that we prepare a summary or an explanation of your PHI. If we maintain your PHI in electronic format, you may request to view your PHI in that format. You may request that we provide copies or the summary in a format other than photocopies. We will use the format you request unless it is not practicable. To obtain copies or a summary, you must make a request in writing and provide us a reasonable amount of time to respond, generally thirty (30) days. You may send a letter to or request a form from us using the contact information listed at the end of this Notice of Privacy Practices. We will charge you a reasonable cost-based fee for expenses such as copies, postage, scanning cost, electronic data compilation costs, and/or staff time. Contact us using the information listed at the end of this Notice of Privacy Practices for a full explanation of fees for your request.

Notification of a Breach: We will notify you of a breach of your unsecured PHI, as required by HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH).

Disclosure Accounting: You have the right to receive a list of instances, if any, in which we or our business associates or their subcontractors disclosed your PHI for purposes other than treatment, payment, healthcare operations, and other permitted uses as described in this Notice of Privacy Practices, for the last 3 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests. You have the right to request such an accounting in an electronic format.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in emergency circumstances.

Electronic, Alternative, or Confidential Communication: You have the right to request, in writing, that we communicate with you about your PHI by alternative means, such as in electronic format, or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation regarding how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request, in writing, that we amend your PHI. Your request must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice of Privacy Practices on our website or by e-mail, you are entitled to receive a copy in written form.

PATIENT NAME (PRINT) DATE OF BIRTH

QUESTIONS AND COMPLAINTS

If you have any concerns that we may have violated your privacy rights, or if you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI, or to have us communicate with you by alternative means or at alternative locations, you may contact us using the information listed below.

In addition, you may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the contact information for filing a complaint upon request. We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Contact Officer: Patricia Conte
Address: 379 Egg Harbor Road
Telephone: (856) 582-0090
Fax: (856) 582-5747
Email: patti@drcjconnolly.com

PATIENT NAME (PRINT) DATE OF BIRTH