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# Drs Bankhead and Groipen DDS PC

## NOTICE OF PRIVACY PRACTICES

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

**PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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### **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

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

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### **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information 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 or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information 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. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. 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 pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

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

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

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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## **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form upon request.

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## **QUESTIONS AND COMPLAINTS**

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

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

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

Contact Officer: David Chapman

Telephone: 1-617-364-5500

Fax: 1-617-361-1351

E-mail: [Privacy@bankheadandgroipen.com](mailto:Privacy@bankheadandgroipen.com)

Address: 1259 HydePark Ave, Hyde Park, MA 02136

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**Drs Bankhead and Groipen DDS PC**  
**ACKNOWLEDGEMENT**  
**OF RECEIPT OF**  
**NOTICE OF PRIVACY PRACTICES**

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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**For Office Use Only**

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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# Drs. Bankhead and Groipen



## PATIENT REGISTRATION AND MEDICAL HISTORY

Patient \_\_\_\_\_  
Last Name First Name Middle Initial Nickname

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-Mail \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ Marital Status \_\_\_\_\_ Spouse/Partner \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Occupation \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name of Dental Insurance Company \_\_\_\_\_

Name of Subscriber \_\_\_\_\_ Subscriber Number \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_ Relation to patient \_\_\_\_\_

In case of an emergency, who should be notified? \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Other Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Who can we thank for referring you to our office? \_\_\_\_\_

### DENTAL HISTORY

Why have you come to the dentist today? \_\_\_\_\_

My last dental cleaning was \_\_\_\_/\_\_\_\_/\_\_\_\_ My last dental exam was \_\_\_\_/\_\_\_\_/\_\_\_\_

- |  | Y                        | N                        |
|--|--------------------------|--------------------------|
| Have you ever had to pre-medicate before dental treatment?                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a serious/difficult problem associated with dental work? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you smoke or use tobacco in any other form?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you now or did you ever clench or grind your teeth?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you now or have you ever experienced pain/discomfort in your jaw (TMJ)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you get sores on your lips or gums?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Are your teeth sensitive to heat, cold or something else?                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do your gums ever bleed?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Is there any other significant dental history that we should know about?   | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, please explain \_\_\_\_\_

On a scale of 1-10 how would you rate your smile? \_\_\_\_\_ What would you do specifically to make your smile a 10? \_\_\_\_\_

## MEDICAL HISTORY

Name of physician: \_\_\_\_\_ Phone#: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Date of last visit: \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you ever been hospitalized? If yes, please explain \_\_\_\_\_

**In order to care for you to the best of our abilities, please answer the following.**

**Y N**

- Cardiovascular Disease  
Congenital Heart Disease, Heart Disease, Heart Attack, Angina
- Rheumatic Fever
- Heart Murmur  
Mitral Valve Prolapse, Damaged Valves
- High or Low Blood Pressure
- Blood Disorders  
Hemophilia, Anemia
- Artificial Joint, Heart Valve
- Cardiac Pacemaker
- Metal Rods, Pins, Implants
- Hepatitis A B C
- AIDS/HIV
- Stroke
- Epilepsy/Seizures
- Cognitive or Intellectual Impairments  
ADD/ADHD, Autism, etc

**Y N**

- Drug/Alcohol Abuse
- Sexually Transmitted Disease
- Thyroid Problems
- Ulcers
- Glaucoma
- Sinus Trouble
- Limited Mobility or Dexterity  
Arthritis, Back Pain, Multiple Sclerosis, etc
- Asthma
- Problems with Mental Health
- Lung Disease
- Tuberculosis
- Cancer/Tumor
- Diabetes  
Patient, Family History

### ALLERGIES/REACTIONS

- |                          |  |                          |  |
|--------------------------|--|--------------------------|--|
| <b>Y</b>                 | <b>N</b>                                   | <b>Y</b>                 | <b>N</b>                               |
| <input type="checkbox"/> | <input type="checkbox"/> Codeine/Narcotics | <input type="checkbox"/> | <input type="checkbox"/> Tetracycline  |
| <input type="checkbox"/> | <input type="checkbox"/> Aspirin           | <input type="checkbox"/> | <input type="checkbox"/> Anesthetics   |
| <input type="checkbox"/> | <input type="checkbox"/> Penicillin        | <input type="checkbox"/> | <input type="checkbox"/> Latex         |
| <input type="checkbox"/> | <input type="checkbox"/> Erythromycin      | <input type="checkbox"/> | <input type="checkbox"/> Metals        |
| <input type="checkbox"/> | <input type="checkbox"/> Sulfa             | <input type="checkbox"/> | <input type="checkbox"/> Environmental |

**Other** \_\_\_\_\_

### WOMEN

- |                          |                          |                   |
|--------------------------|--------------------------|-------------------|
| <b>Y</b>                 | <b>N</b>                 |                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Contraceptives?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Hormones?         |
| <input type="checkbox"/> | <input type="checkbox"/> | Menopause?        |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you nursing?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? |
- If so, how far along? \_\_\_\_\_

### MEDICATIONS

Please list any prescription or over the counter medications you are taking at this time.


Do you have any disease, condition or problem not listed above that you think we should know about? If yes, please explain.

**I UNDERSTAND** that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
(If under 18, Parent or Guardian signature required.)



# Drs. Bankhead and Groipen



**Patient Name:** \_\_\_\_\_

## **Consent To Treatment**

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray or other studies that may be used by the attending doctor, or his nurse or qualified designate.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

(If under 18, Parent or Guardian signature required.)

## **Financial Policy**

Payment and deductibles are due at the time of service. Payment can be made with the following options:

- A.** Cash
- B.** Personal check
- C.** Major credit card (Mastercard, Visa, American Express, Discover)
  - a. Including flexible spending plan cards
- D.** CareCredit

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

(If under 18, Parent or Guardian signature required.)

## **Cancellation Policy**

We will make every effort to schedule your appointments to accommodate your needs. If you are unable to keep your appointment, please notify us as soon as possible. This courtesy makes it possible to give the appointment to another patient. If you do not cancel within 24 hours, a cancellation fee will be applied to your account.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

(If under 18, Parent or Guardian signature required.)

*\*Please speak with our financial department for details on CareCredit.*