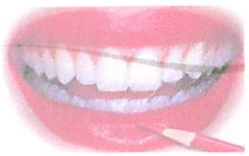

Gary R Login DMD

NEW PATIENT MEDICAL HISTORY

General information Date:_____

Name_____ Phone Number:_____

Address:_____

Date of Birth:_____ Gender:_____

Email:_____ Nickname:_____

Emergency Contact:_____ Relationship:_____

Emergency Contact Phone/Email:_____

Referal Source:_____

Dental Insurance:_____ Subscriber ID:_____

Subsciber Name:_____ Relationship:_____

I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. Patient Signature:_____

Current Employer

Company/Organization_____

Current Educational Institution

School/College/University/Etc_____

Physician and/or Primary Health Care Provider

Doctor/Other_____ Phone:_____

Address:_____

May I share information with your physician or primary care provider and consult with them as necessary? ____ YES ____NO

Patient Signature:_____

Medical History

Are you currently in good health? ____ YES ____NO

What was the date of your last physical examination? _____

Are you currently being treated for any medical condition? If so, please describe:_____

_____

Gary R. Login, DMD

List any prescription medications you are now taking: _____

_____

List any self-prescribed supplements, vitamins and/or homeopathic remedies you are now taking: _____

_____

Have you had any serious illness, surgery, or been hospitalized in the past 5 years? If so, please describe: _____

_____

Do you have or have you had any of the following diseases or problems (check those questions to which you answer yes and leave the others blank):

- ☐ Damaged or artificial heart valves, including murmur or rheumatic heart disease
- ☐ Cardiovascular disease (heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke, etc)
    - o Shortness of breath after mild exercise or lying down
    - o Swelling in ankles
    - o Chest pain exertion
    - o Congenital heart defects
    - o Pacemaker
- ☐ Arthritis or painful swollen joints; hip, knee or other joint replacement
- ☐ Persistent cough that produces blood
- ☐ Diabetes/relatives with diabetes
- ☐ Epilepsy/other neurological disease
- ☐ Fainting spells or seizures
- ☐ Hepatitis, jaundice or liver disease
- ☐ Persistent diarrhea or weight loss
- ☐ Stomach ulcer or acid reflux
- ☐ Respiratory problems
- ☐ Sinus problems
- ☐ Asthma or hay fever
- ☐ HIV/AIDS
- ☐ Abnormal bleeding
- ☐ Blood transfusions
- ☐ Sexually transmitted disease
- ☐ Tuberculosis
- ☐ Thyroid problems
- ☐ Allergies
- ☐ Kidney trouble
- ☐ Tuberculosis
- ☐ Low blood pressure
- ☐ Mental health problems
- ☐ Immune system problems
- ☐ Cancer
- ☐ Anemia
- ☐ Treatment for tumor or growth

Are you allergic or have any reaction to:

- ☐ Local anesthetics
- ☐ Penicillin or other antibiotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives or sleep aids
- ☐ Aspirin
- ☐ Iodine
- ☐ Codeine or other narcotics
- ☐ Other _____

Gary R. Login, DMD

Women:

- ☐ Are you pregnant?
- ☐ Nursing?
- ☐ Taking birth control pills?
- ☐ Experiencing menstrual problems?

Are you wearing contact lenses? Yes No
Do you use tobacco products? If yes, how often? Yes No

Dental History

When/Where was your last dental visit? _____
Have you been advised to take medication prior to dental treatment? Yes No
Have you had any serious complications associated with previous dental treatment? Yes No
Do you wear removable dental appliances? Yes No
What are your main dental concerns?

_____
_____
_____

Do you have any disease, condition or problem not listed above that you think I should know about? If so, please explain:

_____
_____
_____

I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____
Patient Signature

Dr. Gary R. Login's Cell Phone Use Policy

1. I consent to Dr. Gary R. Login's dental practice using my cell phone number (_____-_____-_____) to (choose one or both) call or text regarding appointments. _____ Initials

2. I consent to Dr. Gary R. Login's dental practice using my cell phone number (_____-_____-_____) to call regarding treatment, insurance, and/or my account. _____ Initials

3. I understand that I can revoke my decision(s) above at any time. _____ Initials.

Gary R. Login, DMD

PERSONAL DENTAL PREFERENCES

Name: _____ Date: _____

Please rate on a scale of 1-5 the importance of each of the following regarding your dental care. (The most important would be #1, do not use the same number twice.)

___ Preventive Dental Health care
___ Excellence and Quality of service
___ Other
___ Freedom from pain
___ Cost and Affordability

Please rate, as above, what a dentist has to do to gain your confidence.

___ Show me what he/she is doing or needs to do so I can clearly understand what is happening.
___ Listen to my concerns and explain thoroughly the procedures to be performed.
___ Make sure I feel comfortable and informed at all times.

Please circle the level of fear you have about your dental visits. (10 being the greatest fear.)

1 2 3 4 5 6 7 8 9 10

I would like to know about these options available to me for maximizing my comfort and my experience during my visit. (Check all that apply.)

___ Music
___ Patient education materials

Are you concerned about the following? (Yes or No):

___ Existing discomfort?
___ Replacing old silver fillings?
___ Recurring or untreated gum disease?
___ Mouth odor?
___ Whitening your teeth?
___ Appearance of my smile?
___ Prevention of decay?
___ Other

PLEASE CIRCLE ONE:

When discussing my treatment plan, I prefer (please circle choice):

THE BIG PICTURE DETAIL BY DETAIL

When evaluating my smile. It is most important:

WHAT I SEE WHAT OTHERS SEE

Gary R. Login, DMD

Health Insurance Portability and Accountability Act of 1996

HIPAA OMNIBUS
NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003
Revised: March 25, 2013

Kara Keller
Kara@garylogin.com

By signing the Acknowledgement form you are only acknowledging that you received, or have been given the opportunity to receive, a copy of our Notice of Privacy Practices.

Patient Signature **Date**

HIPAA Omnibus
Notice of Privacy Practices

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your Protected Health Information (PHI) to carry out Treatment, Payment or Health Care Operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. Please review it carefully.

We reserve the right to change this notice at any time and to make the revised or changed notice effective in the future. A copy of our current notice will always be posted in the waiting area. You may also obtain your own copy by accessing our website at www.garylogin.com or calling the Privacy Officer at 617-277-0807.

Some examples of Protected Health Information include information about your past, present or future physical or mental health condition, genetic information, or information about your health care benefits under an insurance plan, each when combined with identifying information such as your name, address, social security number or phone number.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

There are some situations when we do not need your written authorization before using your health information or sharing it with others, including:

Treatment: We may use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. For example, your Protected Health Information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your Protected Health Information may be used, as needed, to obtain payment for your health care services after we have treated you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your treatment.

Healthcare Operations: We may use or disclose, as-needed, your Protected Health Information in order to support the business activities of our practice, for example: quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities.

Appointment Reminders and Health-related Benefits and Services: We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your Protected Health Information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

Friends and Family Involved in Your Care: If you have not voiced an objection, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for your care, including following your death.

Business Associate: We may disclose your health information to contractors, agents and other "business associates" who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, a billing company, an accounting firm, or a law firm that provides professional advice to us. Business associates are required by law to abide by the HIPAA regulations.

Proof of Immunization: We may disclose proof of immunization to a school about a student or prospective student of the school, as required by State or other law. Authorization (which may be oral) may be obtained from a parent, guardian, or other person acting in loco parentis, or by the adult or emancipated minor.

Incidental Disclosures: While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

Emergencies or Public Need:
We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you.

We may use or disclose your Protected Health Information in the following situations without your authorization: as required by law, public health issues, communicable diseases, abuse, neglect or domestic violence, health oversight, lawsuits and disputes, law enforcement, to avert a serious and imminent threat to health or safety, national security and intelligence activities or protective services, military and veterans, inmates and correctional institutions, workers' compensation, coroners, medical examiners and funeral directors, organ and tissue donation, and other required uses and disclosures. We may release some health information about you to your employer if you employer hires us to provide you with a physical exam and we discover that you have a work related injury or disease that your employer must know about in order to comply with employment laws. Under the law, we must also disclose your Protected Health Information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

REQUIREMENT FOR WRITTEN AUTHORIZATION

There are certain situations where we must obtain your written authorization before using your health information or sharing it, including:

Most Uses of Psychotherapy Notes, when appropriate.

Marketing: We may not disclose any of your health information for marketing purposes if our practice will receive direct or indirect financial payment not reasonably related to our practice's cost of making the communication.

Sale of Protected Health Information: We will not sell your Protected Health Information to third parties.

You may revoke the written authorization, at any time, except when we have already relied upon it. To revoke a written authorization, please write to the Privacy Officer at our practice. You may also initiate the transfer of your records to another person by completing a written authorization form.

PATIENT RIGHTS
Right to Inspect and Copy Records. You have the right to inspect and obtain a copy of your health information, including medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the practice. We may charge a fee for the costs of copying, mailing or other supplies. If you would like an electronic copy of your health information, we will provide one to you as long as we can readily produce such information in the form requested. In some limited circumstances, we may deny the request. Under federal law, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information related to medical research where you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

Right to Amend Records. If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment in writing. If we deny your request, we will provide a written notice that explains our reasons. You will have the right to have certain information related to your request included in your records.

Right to an Accounting of Disclosures. You have a right to request an "accounting of disclosures" every 12 months, except for disclosures made with the patient's or personal representatives written authorization; for purposes of treatment, payment, healthcare operations; required by law, or six (6) years prior to the date of the request. To obtain a request form for an accounting of disclosures, please write to the Privacy Officer.

Right to Receive Notification of a Breach. You have the right to be notified within sixty (60) days of the discovery of a breach of your unsecured protected health information if there is more than a low probability the information has been compromised.

Right to Request Restrictions. You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, run our normal business operations or disclose information about you to family or friends involved in your care. Your request must state the specific restrictions requested and to whom you want the restriction to apply. Your physician is not required to agree to your request except if you request that the physician not disclose Protected Health Information to your health plan when you have paid in full out of pocket.

Right to Request Confidential Communications. You have the right to request that we contact you about your medical matters in a more confidential way, such as calling you at work instead of at home. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.

Right to Have Someone Act on Your Behalf. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

Right to Obtain a Copy of Notices. If you are receiving this Notice electronically, you have the right to a paper copy of this Notice.

Right to File a Complaint. If you believe your privacy rights have been violated by us, you may file a complaint with us by calling the Privacy Officer at 617-277-0307 or with the Secretary of the Department of Health and Human Services. We will not withhold treatment or take action against you for filing a complaint.

Uses and Disclosures Where Special Protections May Apply. Some kinds of information, such as alcohol and substance abuse treatment, HIV-related, mental health, psychotherapy, and genetic information, are considered so sensitive that state or federal laws provide special protections for them. Therefore, some parts of this general Notice of Privacy Practices may not apply to these types of information. If you have questions or concerns about the ways these types of information may be used or disclosed, please speak with your health care provider.

Gary R. Login, DMD

Appointment Accountability Agreement

Welcome to the practice! We would like to share our policy regarding missed appointments.

"No-shows" and last-minute cancellations inconvenience those patients needing access to dental care. We know life is hectic and that it may occasionally be necessary to cancel your scheduled appointment. In order to provide optimal care for all of our patients, we kindly require that you notify us a minimum of two business days in advance. Appointments are in high demand, and your respectful notice will allow another patient in need the opportunity to be cared for.

- First missed appointment: inconvenience fee waived
- Second missed appointment: inconvenience fee $75
- Third missed appointment: inconvenience fee $100

By signing below, you acknowledge that you have read and understand our practice's Appointment Accountability Agreement.

We look forward to being your dental home. Thank you for your understanding and cooperation.

Gary R. Login

Patient Signature: _____ Date: _____

Printed Name: _____