Stuparich & Nouel

Dental Associates, LLP

New Patient Information Form

Name_____ Title_____

Home Address_____

Street apt. # city state zip

SS# _____ D.O.B. ____/____/____

Home Phone_____ Work Phone_____ Cell Phone_____

E-mail Address_____

Sex_____ Marital Status_____

Referring Dr._____ Referring Patient_____

Dental Insurance:

Subscriber Name_____ Relationship to Patient_____

ID#_____ Employer _____

D.O.B. of Subscriber_____/_____/_____ Group #_____

Plan Name_____ Insurance Company_____

MailClaimsTo_____

Individual Deductible_____ Family Deductible_____

Yearly Maximum_____

Are you happy with your smile ?_____

If there is one thing you could change about your smile, what would that be?

The above information is true to the best of my knowledge:

Signature date

Dr. Alexandria Nouel • Dr. Mauro Stuparich • 321 Columbus Ave., Suite 1R Boston, MA 02116 • phone: 617-437-6800 fax: 617-437-1900

www.abostonsmile.com

Confidential Medical History:

Date of last physical exam_____

Have you recently been under the care of a physician, if yes, for what reason? \

_____

_____

Have you ever been hospitalized for a prolonged period or had any serious illness?

_____

Do you smoke, or use tobacco in any form? _____

Please check any of the following that you have, had or suspected that you had.

____Arthritis	____Hepatitis or Jaundice	____Prolonged Bleeding
____Rheumatic Fever	____Liver Disease	____Fainting Tendency
____Heart Trouble	____Cancer or Tumor	____Epilepsy
____Heart Murmur	____Tuberculosis	____Thyroid Disease
____High/Low Blood Pressure	____Diabetes	____Glaucoma
____Chest Pain	____Kidney/ Bladder Trouble	____Radiation Tx.
____Stroke	____Anemia	____Mental Disorders
____Shortness of Breath	____Lung Disease	____HIV or AIDS
____Asthma/ Hay Fever	____Venereal Disease	____Prosthetic Joint
____Sinus Trouble	____Blood Disease	____Blood Transfusion

Other_____

Check any of the following that you are taking or have taken:

_____Cortisone Drugs	____Anticoagulants	____Tranquilizers
_____Steroids	____Blood Thinners	____Other: _____

Any known allergies:

____Penicillin	____Erythromycin	____DentalAnesthetics	____Latex
____Codeine	____Tetracycline	____Metals	

Other_____

WOMEN ONLY: Are you pregnant? _____
If yes, how many months? _____
Are you breast feeding? _____

Are you presently taking medicine of any kind, routinely? _____
(birth control, hormone therapy, antidepressants, etc.) Explain_____

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FINANCIAL AGREEMENT

Thank you for coming to see us for your dental care. At this time, we would like to inform you of our practices' financial terms. We appreciate receiving payment when services are rendered either a Delta Dental Insurance Co-payment or full payment for the visit. We accept cash, checks, Mastercard, Visa, American Express, Care Credit, and the Dental Fee Plan. *

Patients who have insurance, but it is not Delta Dental, will be asked to pay in full for all services, since your dental insurance will not pay our office directly. However, we will be happy to send a claim so that you may be reimbursed.

All co-pays will be expected in full at the time of service. Patients who are self-pay will be expected to pay in full at the time of service.

Your signature below indicates that you:

1. Have read and understood the above information.
2. Authorize and request payment under Delta Dental Insurance Program be made to the office of Stuparich & Nouel Dental Associates for covered services.
3. Acknowledge responsibility for all charges incurred for treatment regardless of your insurance coverage.
4. Permit a copy of this authorization to be used in place of the original.

Signature Date

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Release

I,_____, grant Stuparich &Nouel Dental Associates a license to reproduce and use any photographs, still or video images, or audio recordings of me, and any testimonial issue regarding my health care services at Stuparich & Nouel Dental Associates, for any of the following purposes:

Stuparich &Nouel Dental Associates website, social media, online and printed articles, mass advertising mailings, brochures, booklets, flyers, reports, event displays and other similar marketing materials and/or activities directed to prospective patients within a 100 mile radius of Stuparich & Nouel Dental Associates.

Stuparich & Nouel is authorized to use all or any portion of the Marketing Materials without royalty or recompense of any kind, in unlimited quantities and for an unlimited period of time.

I release Stuparich & Nouel Dental Associates and any of its associated or affiliated companies, their owners, directors, officers, agents, employees and appointed advertising agencies from all claims of any kind arising out of the use of Marketing Materials as described in the Release.

In the event I want Stuparich & Nouel to cease using the Marketing Materials, I understand I must provide 60 day written notice to Stuparich & Nouel shall have the right to continue to use the Marketing Materials during the 60 day notice period and shall further have the right to exhaust its supply if products containing any portion of the Marketing Materials ordered or received prior to Stuparich & Nouel Dental Associates's receipt of written notice.

Signature:_____

Print Name:_____

Date:_____

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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

For Office Use Only

We attempted obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could 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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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT
Name:_____
Address:_____
Telephone:_____ Email:_____
Patient Number:_____ Social Security Number:_____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we make of your protected health information. A copy of our Notice accompanies this Consent. We encourage you read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, Including any revisions of our Notice, at any time by contacting.

Contact Person: STUPARICH & NOUEL DENTAL ASSOCIATES
Telephone: 617 437-6800 Fax:_____
Email: info@abostonsmile.com
Address: 321 COLUMBUS AVE. SUITE 1R BOSTON MA 02116

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

B. SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date:_____