PETERBOROUGH FAMILY DENTAL
& Implant Center

Patient Name: _____

Welcome! We want to thank you for allowing us to help you with your dental needs. If you have any questions or concerns after today's appointment, please feel free to ask any of our staff members.

We would greatly appreciate if you could take a moment to tell us how you heard about our office. Please write here:

Thank you from Dr. Jasper Ainslie, Dr. Muhammad Abdel-Rahim, and the entire staff at Peterborough Family Dental & Implant Center

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____

Responsible Party (if different from patient or patient is a minor): _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ □ I would like to receive text message correspondence

Email: _____ □ I would like to receive email correspondence

Emergency Contact Name & Phone: _____

Dental Insurance Information

Ins. Company: _____ Subscriber: _____

Subscriber Date of Birth: _____ Relationship to Subscriber: □ Self □ Spouse □ Child □ Other

Subscriber ID: _____ Subscriber Social Security: _____

Employer Name: _____ Group Number: _____

Dental History

Please briefly describe your reason for today's visit and/or any dental concerns:

Approx. date of last exam: _____ Approx. date of last cleaning: _____

Approx. date of last x-ray: _____ Have you ever received local anesthesia? Yes No

Have you ever been treated for periodontal (gum) disease? Yes No Unsure

Have you ever had a traumatic dental experience or needed restraint or sedation to receive care? If yes, please explain:

Do you feel as though there are obstacles that prevent you from receiving treatment or maintaining good dental health? If yes, please explain:

Is there anything else we should know about your dental experiences or preferences in order to provide you with the best care?

DENTAL PATIENT INFORMED CONSENT

THE FOLLOWING IS A LIST OF COMMON RISKS AND/OR COMPLICATIONS WHICH MAY OCCUR DURING AND/OR AFTER DENTAL TREATMENT AND/OR DENTAL SURGERY. THIS LIST DOES NOT ITEMIZE EVERY POSSIBLE RISK AND THE PATIENT OR GUARDIAN IS HEREBY ADVISED TO SEEK A SECOND OPINION REGARDING ANY DENTAL TREATMENT WHICH THEY DO NOT FULLY UNDERSTAND. PLEASE READ THIS FORM CAREFULLY. YOU SHOULD UNDERSTAND THAT SINCE DENTISTRY IS NOT AN EXACT SCIENCE, NO SPECIFIC RESULT IS PROMISED OR GUARANTEED. ALTHOUGH THE STAFF AT PETERBOROUGH FAMILY DENTAL & IMPLANT CENTER DOES NOT EXPECT YOU TO SUFFER UNNECESSARY COMPLICATIONS, YOU ARE HEREBY ADVISED THAT IT IS A POSSIBILITY. YOUR SIGNATURE ON THIS FORM IMPLIES THAT YOU UNDERSTAND, TO THE BEST OF YOUR ABILITY, AND ACCEPT THE RISKS, AND/OR COMPLICATIONS WHICH MAY OCCUR DURING YOUR DENTAL TREATMENT. YOU ACKNOWLEDGE THAT THE RISKS HAVE BEEN ADEQUATELY EXPLAINED TO YOU IN A MANNER WHICH YOU UNDERSTAND, AND THAT YOU REALIZE THE FOLLOWING LIST DOES NOT REPRESENT A COMPLETE EXPLANATION OF EVERY RISK YOU MAY ENCOUNTER IN THIS OR ANY OTHER OFFICE.

1. X-rays are a form of radiation and should be avoided during pregnancy. If you ever visit this office while pregnant or suspicious of a pregnancy, it is YOUR responsibility to notify Dr. Jasper Ainslie or Dr. Muhammad Abdel-Rahim and REFUSE X-RAYS. Since most dental procedures are diagnosed and treated with the aid of x-rays, you must understand that we will require you to receive x-rays for most of the procedures we provide. A lead apron is provided for your use and protection.
2. The administration of local anesthetic will make you numb for 1-16 hours. You should bite carefully to prevent injuring yourself during this time. It will also leave you with soreness or discomfort for several minutes to several days. If this is unacceptable, then you should request that minor treatment be performed without anesthetic, or schedule your appointment for a time when this discomfort is not going to be a problem.
3. A routine injection may injure or sever a nerve, leaving you with long-term or permanent anesthesia paresthesia. A routine injection may also puncture a blood vessel, causing hemorrhage or hematoma. If this occurs, call our office. Further treatment may be necessary from Dr. Jasper Ainslie or Dr. Muhammad Abdel-Rahim or a dentist of their choice.
4. Extraction of an erupted or impacted tooth or root tip may result in the same symptoms as described in item #3. Extraction of an upper tooth may result in loss of all or part of the tooth into a sinus cavity requiring further surgery from Dr. Jasper Ainslie or Dr. Muhammad Abdel-Rahim or a dentist of their choice. It is possible for an upper tooth to be successfully extracted while still opening an oral/antral fistula into a sinus. If your sinus is exposed, you will likely require further surgery from Dr. Jasper Ainslie or Dr. Muhammad Abdel-Rahim or a dentist of their choice. In the event either of these surgical procedures is required, you should avoid sucking on straws or blowing up balloons (or similar activities) for at least 6-8 weeks. If you feel unexplained air pressure leaking between your mouth and sinuses after an upper extraction, YOU are expected to call this office.
5. Teeth are often filled or crowned with gold, silver, or other substances, which conduct hot, cold, and other stimuli extremely well. Most teeth are sensitive from 3 days to 3 weeks; however, some teeth are sensitive much longer or perhaps permanently. If your sensitivity persists, you will likely require pulpal treatment or root canal from Dr. Jasper Ainslie or Dr. Muhammad Abdel Rahim or a dentist of their choice. This sort of sensitivity generally results from large carious legions, large restorations, large immature pupals, hairline cracks, or reduction for fixed prosthetics; but HAS ALSO BEEN SHOWN TO OCCUR FOR NO KNOWN REASON.
6. Teeth that are crowned are often teeth which have fractured or have been repeatedly filled. Even a perfectly healthy tooth must be substantially reduced to receive a crown. This is particularly true with tipped, crooked, or mal-occluded teeth. This reduction may cause sensitivity and can lead to future pupal treatment or root canal therapy. Teeth which have been crowned NEVER have perfect margins. As you age or your gingival tissue recedes, the margin is exposed and may cause the tooth to be more sensitive. In some instances, the pulp must be treated and/or the crown replaced. Porcelain behaves like glass and can easily fracture by hard foods or a blow to the mouth. Some long fixed bridges flex enough to fracture the porcelain covering. Fractured

porcelain prosthetics are seldom repairable. Dr. Jasper Ainslie and Dr. Muhammad Abdel-Rahim do not accept responsibility for fractured porcelain since it is out of their control. The patient is, however, advised that metal jacket coping adequately protects the tooth with or without the porcelain covering.

7. Pulpal treatment or root canal therapy involves the placement of tiny fragile instruments into a tiny, often restricted canal. These instruments can, and do, occasionally fracture inside the tooth. If this occurs, your attending dentist Dr. Jasper Ainslie or Dr. Muhammad Abdel-Rahim may attempt to remove the instrument or refer you to an endodontist to have it removed. If it is not or cannot be retrieved, we will advise you of its presence. In many cases, the fractured piece actually seals the canal, so no further treatment is needed. While filling a root canal, it is possible to extrude gutta percha or root canal cement beyond the apex of the tooth. Even during routine canal therapy, it is possible for painful symptoms to persist. If symptoms persist following any of these circumstances, you will likely require a surgical apico-ectomy and/or retrofill that may be performed by an endodontist or dentist of their choice. If the symptoms are still not relieved, then it is likely that the tooth will require extraction.
8. Removable dentures and partial dentures are plastic and/or metal appliances that at best are uncomfortable, clumsy, and feel loose. Because they are not cemented in place, they rub your gingival and lateral torque. A partial clasp can cause food traps, periodontal disease, tooth decay, and loss of adjacent teeth and cause scarring and lateral torque. You are advised to keep these appliances as clean as possible and have them examined regularly in this office.
9. Crowns, fixed bridges, fillings, dentures, root canals, and most other dental treatments are the dentist's attempt to correct or prevent dental disease. These forms of treatment are not intended to substitute for healthy teeth but rather substitute unhealthy and/or missing teeth. Dental treatment is not always successful at first. Some teeth or appliances need to be retreated or treated differently and SOME DO NOT RESPOND FAVORABLY TO ANY TREATMENT and are eventually extracted. Dental treatment may succeed at first and then suffer recurrent caries, fractures, abscess, or pain in the future. You should visit this office no less than once per year to give Dr. Jasper Ainslie and Dr. Muhammad Abdel-Rahim the greatest possibility of serving you. YOU are encouraged to call if you ever have questions or complaints about your treatment. You will find the staff eager to make you comfortable.
10. Some patients present to the dental office with compromising health conditions. A history of HIV/AIDS, heart disease, rheumatic fever, bleeding disorders, liver disease, hepatitis, kidney disease, lung disease, or an allergy or sensitivity to penicillin, erythromycin, codeine, Percodan, Hycodaphen, aspirin, Tylenol, Empirin, Xylocaine, Carbocaine, or Novacaine may qualify you as an unjustifiable risk for this office. YOU are expected to circle any of the above conditions which you are EVEN SUSPECTED of having on your medical history and notify Dr. Jasper Ainslie or Dr. Muhammad Abdel-Rahim IN PERSON. FAILURE TO DO SO COULD RESULT IN SERIOUS INJURY OR DEATH. If you have a history of heart disease or other serious ailment, you will be required to have your physician consult with Dr. Jasper Ainslie or Dr. Muhammad Abdel-Rahim to determine whether or not you can be safely treated in this office. Even when precautions are taken, it is possible that you could suffer an exacerbation of your condition and/or its related complications.
11. Prescribing medications is routine in a dental practice. Antibiotics are prescribed for the control of infection; narcotic and non-narcotic analgesics are prescribed for the control of pain. Sedative/hypnotics are sometimes prescribed for the control of anxiety. Fluoride tablets and rinses are prescribed for the caries reduction. MANY OF THE PRESCRIPTIONS WRITTEN IN THIS OFFICE CAN AND DO REACT UNFAVORABLY WITH MANY OTHER MEDICATIONS. If you are taking other medications at the time you are offered a prescription, YOU are expected to remind Dr. Jasper Ainslie and Dr. Muhammad Abdel-Rahim of all medications you are then using. If you are using or abusing controlled substances, marijuana, narcotics, or any other drug(s), YOU are expected to give this information to Dr. Jasper Ainslie or Dr. Muhammad Abdel-Rahim each time you receive a prescription from this office, so that we may substitute the medication or alter its dosage appropriately. FAILURE TO DO SO COULD RESULT IN DEATH OR SERIOUS INJURY. Antibiotics often render birth control pills ineffective; appropriate precautions must be taken during antibiotic therapy.

NOTICE OF PRIVACY PRACTICES

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.

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 02/01/03 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.

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 text messages, voicemail messages, postcards, or letters).

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. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we may charge you for each page or per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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.

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 may also submit a written complain 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: Sara J. LaFleur
Telephone: (603) 924-3664 Fax: (603) 924-3276
E-mail: slafleur@peterboroughfamilydental.com
Address: 21 Grove Street, Peterborough, NH 03458

NEW PATIENT SIGNATURES

PLEASE READ THIS PAGE FULLY

ACKNOWLEDGMENT OF RECEIPT OF DENTAL PATIENT INFORMED CONSENT

I DO HEREBY ACKNOWLEDGE THAT I HAVE BEEN INFORMED, TO MY SATISFACTION, OF THE RISKS AND/OR COMPLICATIONS OF THE DENTAL TREATMENT WHICH DR. JASPER AINSLIE OR DR. MUHAMMAD ABDEL-RAHIM AND/OR ASSOCIATES IS TO PROVIDE FOR ME (OR MY DEPENDENTS).

Print patient/guardian name: _____

Signature of patient/guardian: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I HAVE RECEIVED AND READ A COPY OF THE NOTICE OF PRIVACY PRACTICES

Print patient/guardian name: _____

Signature of patient/guardian: _____ Date: _____

WITH WHOM MAY WE DISCUSS YOUR CARE?

I give my permission to discuss all aspects of my dental treatment, including financials, payment, and scheduling, to the following individuals listed:

Name(s) and relation(s):

_____

_____

_____

Peterborough Family Dental & Implant Center **Medical History**

PATIENT NAME: _____ **BIRTH DATE:** _____ **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_____
Have you ever been hospitalized or had a major operation? Yes □ No □ If yes_____
Have you ever had a serious head or neck injury? Yes □ No □ If yes_____
Do you take, or have you taken, Phen-Fen or Redux? Yes □ No □ If yes_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes □ No □ If yes_____
Are you on a special diet? Yes □ No □ If yes_____
Do you use tobacco? Yes □ No □
Do you use controlled substances? Yes □ No □ If yes_____
Are you taking any medications, pills, or drugs? Yes □ No □ If yes_____
_____
_____

Women: Are you…
Pregnant/Trying to get pregnant? Yes □ No □ Nursing? Yes □ No □ Taking oral contraceptives? Yes □ No □

Are you allergic to any of the following?

Aspirin Yes □ Penicillin Yes □ Codeine Yes □ Acrylic Yes □
Metal Yes □ Latex Yes □ Sulfa Drugs Yes □ Local Anesthetics Yes □
Other: _____

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

	Y N		Y N		Y N		Y N
AIDS/HIV Positive	□ □	Diabetes	□ □	Hepatitis A	□ □	Recent Weight Loss	□ □
Alzheimer's Disease	□ □	Drug Addiction	□ □	Hepatitis B or C	□ □	Renal Dialysis	□ □
Anaphylaxis	□ □	Easily Winded	□ □	Herpes	□ □	Rheumatic Fever	□ □
Anemia	□ □	Emphysema	□ □	High Blood Pressure	□ □	Rheumatism	□ □
Angina	□ □	Epilepsy or Seizures	□ □	High Cholesterol	□ □	Scarlet Fever	□ □
Arthritis/Gout	□ □	Excessive Bleeding	□ □	Hives or Rash	□ □	Shingles	□ □
Artificial Heart Valve	□ □	Excessive Thirst	□ □	Hypoglycemia	□ □	Sickle Cell Disease	□ □
Artificial Joint	□ □	Fainting/Dizziness	□ □	Irregular Heartbeat	□ □	Sinus Trouble	□ □
Asthma	□ □	Frequent Cough	□ □	Kidney Problems	□ □	Spina Bifida	□ □
Blood Disease	□ □	Frequent Diarrhea	□ □	Leukemia	□ □	Stomach Disease	□ □
Blood Transfusion	□ □	Frequent Headaches	□ □	Liver Disease	□ □	Stroke	□ □
Breathing Problems	□ □	Glaucoma	□ □	Low Blood Pressure	□ □	Swelling of Limbs	□ □
Bruise Easily	□ □	Hay Fever/Allergies	□ □	Lung Disease	□ □	Thyroid Disease	□ □
Cancer	□ □	Heart Attack/Failure	□ □	Mitral Valve Prolapse	□ □	Tonsillitis	□ □
Chemotherapy	□ □	Heart Disease	□ □	Osteoporosis	□ □	Tuberculosis	□ □
Chest Pains	□ □	Heart Murmur	□ □	Pain in Jaw Joints	□ □	Tumors or Growths	□ □
Cold Sores	□ □	Heart Pacemaker	□ □	Parathyroid Disease	□ □	Ulcers	□ □
Convulsions	□ □	Heart Trouble/Disease	□ □	Psychiatric Care	□ □	Venereal Disease	□ □
Cortisone Medicine	□ □	Hemophilia	□ □	Radiation Treatments	□ □	Yellow Jaundice	□ □

Any serious illness or conditions not listed above? _____

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 office of any changes in medical status.
Signature of Patient, Parent, or Guardian:

X_____ Date:_____