Welcome to Our Practice

We are honored that you have selected us as your partner in achieving optimum oral health. The health of your mouth plays an important role in your total well-being. Dental disease can affect your entire body; physically, emotionally and psychologically. Our goal is to work with you to make a lasting improvement to your health through education, prevention, maintenance and treatment when needed.

Please print and complete the New Patient Paperwork and bring it with you to your first appointment. If you have ever been told by a doctor or have any medical condition that requires you to pre-medicate prior to an appointment, we will need you to take the prescribed medication from your Primary Care Physician, Cardiologist and/or your Orthopedic doctor as prescribed. If you have any x-rays from your previous dental office, please have them forwarded to our office at **info@islandpointdentistry.com.**

We thank you for entrusting us with the responsibility of caring for such an important aspect of your health. We are committed to providing you with the highest quality of care and pledge to serve you with respect, compassion and integrity.

We look forward to your visit!

Dr. Rockwood and the Island Point Dentistry Team

Island Point Dentistry LLC, P.A.

PATIENT REGISTRATION

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

Preferred Name: _____

Street/PO Box: _____

City, State, Zip : _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Work Phone: (_____)_____ Ext: _____

Email:_____

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

Sex: ☐Male ☐Female Marital Status: ☐Married ☐ Single

Employment Status: ☐Full time ☐Part-Time ☐Self Employed ☐Retired ☐Student

Primary Care Physician Name: _____ Phone:_____

Preferred Pharmacy:_____

Person to notify in case of emergency:_____ Phone:_____

How did you hear about us?

- ☐ Family Member (name so we may thank them) _____
- ☐ Current Patient (name so we may thank them) _____
- ☐ Website ☐ Other: _____

Responsible Party (Complete if someone other than the patient)

First Name: _____Last Name: _____Middle Initial: _____

Street/PO Box: _____

City, State, Zip Code: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Work Phone: (_____)_____ Ext: _____

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

If you have recent dental x-rays from another office, please contact that office and request your x-rays be emailed to info@islandpointdentistry.com

_____ _____/_____/_____

Signature of Patient/Parent/Guardian Date

Island Point Dentistry LLC, P.A.

DENTAL INSURANCE INFORMATION
(Complete only if you have dental insurance)

Primary Insurance Information:

Name of Policy Holder:_____

Relationship to Patient: □ Self □ Spouse □ Child

Policy Holder's Date of Birth: _____/_____/_____

Policy Holder's Employer: _____

Insurance Company Name:_____

Group Number: _____

Member ID Number: _____Social Security #: _____-_____-_____

Claims Mailing Address:

Street/PO Box: _____

City, State, Zip Code: _____

Telephone Number: (_____)_____

List Patients covered under this policy:

_____

_____

Secondary Insurance Information:

Name of Policy Holder:_____

Relationship to Patient: □ Self □ Spouse □ Child

Policy Holder's Date of Birth: _____/_____/_____

Policy Holder's Employer: _____

Insurance Company Name:_____

Group Number: _____

Member ID Number: _____Social Security #: _____-_____-_____

Claims Mailing Address:

Street/PO Box: _____

City, State, Zip Code: _____

Telephone Number: (_____)_____

List Patients covered under this policy:

_____

_____

Island Point Dentistry LLC, P.A.

MEDICAL HISTORY

PATIENT NAME_____ Birth 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, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

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 ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism Scarlet ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Fever Shingles ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
			◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

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 dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____ DATE _____

Island Point Dentistry LLC, P.A.

DENTAL HISTORY

Name: _____ Date of Birth: _____

When was your last dental visit?_____ What was it for?_____

What are you hoping to achieve from your dental care? _____

_____

What is your level of anxiety/stress/fear when going to the dentist? □None □Mild □Mod □Severe

Do you currently have any tooth discomfort? □ No □ Yes, for how long? _____

Are you happy with the function and appearance of your teeth? □ No □ Yes

If no, please explain_____

Are your jaw joints painful, tender, or get stuck open or closed? □ No □ Yes

Do you have a history of mouth/jaw/head trauma? □ No □ Yes, date: _____

Does your bite feel comfortable? □ No □ Yes

Do you clench or grind your teeth? □ No □ Yes

Have you ever worn a guard or been treated for TMJ/TMD? □ No □ Yes

How often do you brush your teeth? _____ Type of brush and paste? _____

How often do you floss/waterfloss? _____

Do you use a rinse? □ No □ Yes Type and frequency? _____

Do your gums bleed when you clean your teeth? □ No □ Yes

Have you ever been told you have gum disease? □ No □ Yes

If yes, did you have surgical treatment? □ No □ Yes

Recommended Hygiene Interval □ 3 months □ 4 months □ Other_____

Gum disease has been linked with an increased risk for many chronic diseases. Eliminating gum disease is especially important to the oral and overall health of the following patients:

Tobacco Users are more likely to develop gum disease which is more severe and more difficult to eradicate. Gum disease itself has recently been linked with an increased risk for heart disease. Since tobacco users are already at an increased risk for heart disease (and because gum disease only worsens that risk) it is vitally important for tobacco users to do whatever is necessary to eliminate gum disease.

□ Current Tobacco User What form (cig, pipe, chew, etc.) _____
How much/day_____ How long? _____

□ Previous Tobacco User When did you quit?_____

Island Point Dentistry LLC, P.A.

Diabetes is a well- known risk factor for gum disease. Research is confirming that when left untreated, gum disease makes it harder for you to control your blood sugar. Elimination of gum disease can improve your blood sugar control thereby reducing your risk for serious complications.

Have you been diagnosed with Diabetes? □ No □ Yes

How is your diabetes control? □ Good □ Fair □ Poor Date and score of last HA1c_____

Who is your diabetes doctor?_____

Some people are genetically prone to developing gum disease even if they take good care of their mouths. Do you have any **family history of gum disease**? □ Yes □ No □ Don't know

Gum disease may be transmissible, family members should be screened for gum disease.

Do you have a **spouse or significant other with gum disease**? □ No □ Yes

Stress is a well- known risk factor for gum disease. Is your stress level high? □ Yes □ No

Life altering events (loss of job, divorce, death in family, moving to new location, etc.) can be particularly strong factors for gum disease. Are you currently going through any life altering events? □ Yes □ No

If you have **rheumatoid arthritis** you are at an increased risk for gum disease. Emerging research suggests that eliminating gum disease can lessen the crippling effects of arthritis. Have you ever been diagnosed with Rheumatoid Arthritis? □ Yes □ No

Cardiovascular Disease has a firmly established association with periodontal disease. Although there is not enough evidence to support a cause-and-effect relationship between periodontal disease and cardiovascular disease, the American Heart Association and the American Academy of Periodontology have concerns that periodontal disease increases the risk of heart disease. Have you been diagnosed with heart disease? □ Yes □ No

Being overweight is now recognized as a strong risk factor for gum disease. Obesity and gum disease are both risk factors for heart disease and diabetes.

Certain medications can cause significant changes to the health of your gums. Are you taking any of the following medications?

□ Dilantin □ Ca+ Channel Blockers □ Immuno-suppressants for organ transplantation?
□ Fosamax, Fosamax Plus D, Actonel, Boniva, Didronel, Skelid, Aredia, Bonefors, or Zometa for osteoporosis or another reason?

FEMALES Are you:

□ Pregnant □ Nursing □ Taking birth control pills □ Diagnosed with breast cancer?
□ Post-menopausal? Do you have osteoporosis? □ Yes □ No

Have you ever been tested for osteoporosis? □ Yes □ No

Patient Communications (HIPAA)

By Law, without your authorization, Island Point Dentistry LLC., P.A. cannot communicate with:

1. Your Spouse
2. Your Adult Children or Caregivers
3. Your Parents (if you are age 18 or over)

Island Point Dentistry LLC., P.A. may need to communicate with your family or caregivers in the following circumstances:

1. Making appointments
2. Confirming appointments
3. Discussing treatment needed or performed
4. Account or Financial information

Please indicate below the names of people who we may communicate with regarding your appointment, medical/dental or account information:

This information will only change if notified by the patient.

☐ My Spouse _____

☐ My Adult Children _____

☐ My Parents _____

☐ My Caregiver _____

☐ Other _____

☐ I do not wish to allow any of my information to be shared with anyone including my spouse, or any other family member.

Emergency Contact: Name: _____

Phone Number: _____

Patient name printed: _____

Patient/Parent/Legal Guardian Signature: _____

Date: _____

Island Point Dentistry LLC, P.A.

FINANCIAL POLICIES

Your dental health and well-being is our top priority. We only recommend treatment we believe to be in your best interest. You are ultimately responsible for selecting the treatment you feel will help you achieve your dental goals and support good oral health. We will not compromise or limit your treatment choices to comply with insurance company restrictions.

Payment Options:

Patients are financially responsible for all treatment rendered. For your convenience, we accept cash, check, Visa, MasterCard, Discover, American Express and Care Credit Financing.

Insurance: Our goal in keeping our quality of care high and billing costs down, is to eliminate ourselves as the middleman with insurance companies. Your policy is a contract between you and your insurance company. We are not a party to that contract. If you have dental insurance, we will submit your claim electronically and will assist you in receiving the maximum benefit to which you are entitled. Our software enables us to estimate what we anticipate your insurance will pay on each of your claims; however, due to the ever-changing insurance policies, benefits and deductibles, it is only an **estimate**. Pre-treatment estimates can be filed with your insurance company per your request, but even with a pre-treatment estimate, benefits are not guaranteed. We cannot accept responsibility for nonpayment of your insurance claims, nor can we negotiate a settlement on a disputed claim. We recommend you contact your insurance company directly with any questions or concerns. If your insurance has not paid within 90 days of service, the balance due is your responsibility. Co-payment, payment for non-covered services and payment for accounts that are not covered under a dental insurance plan are due at date of service.

Outstanding Accounts: Any balances that are more 90 days old will be subject to review and collection efforts. If a satisfactory arrangement is not made or upheld, we reserve the right to transfer the account to an outside collection agency. We realize that temporary financial situations may affect your ability to pay your account in a timely manner. If this is the case, please contact us promptly for assistance in the management of your account.

Reservation of Appointments: We do our best to reserve appointment time that accommodates your needs. We ask that you kindly give a 48 hour notice if you need to reschedule an appointment. This allows us time to offer this time to a patient in need. If we do not receive adequate notice, we reserve the right to assess a $50 fee for the missed appointment time. We understand that emergencies happen, and will work with you as well as we can.

It is our pleasure to serve your dental health needs and we welcome any questions or concerns you may have regarding our policies.

I have read, understand, and agree to the policies for Island Point Dentistry LLC, P.A.

_____ _____

Signature of Patient/Parent/Guardian Date

Island Point Dentistry LLC, P.A.

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 07/14/2014 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such ;;'s HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protection under applicable State or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to, but not limited to, a lab, specialist, or pharmacy providing treatment to you. We may also leave you voicemail messages and mail appointment reminder postcards to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We will not use your health information for this purpose without your permission. For example, healthcare operations include quality assessment and improvement activities, conducting training programs and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:
-Prevent or control disease, injury or disability;
-Report child abuse or neglect;
-Report reactions to medications or problems with products or devices;
-Notify a person of a recall, repair, or replacement of products or devices;
-Notify a person who may have been exposed to a disease or condition;
-Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the US Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights law.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a

court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We will not use your information for this purpose without your permission.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We will never use your information for this purpose.

Teaching and Educational Purposes. We may use your case and dental records in a non-identifiable manner for educational purposes.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies, If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. You have a right to see our standard fees.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health car item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

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 if 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 US Department of Health and Human Services. We will provide you with the address to file your complaint with the US 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 US Department of Health and Human Services.

Island Point Dentistry LLC, P.A.
110 Main Street, Suite 1218
Saco, ME 04072
(207) 284-4007 (207)284-4096 Fax

Island Point Dentistry
LLC, P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of Island Point Dentistry Notice Of Privacy Practices.

Printed Name: _____

Signature: _____ Date: _____

Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices; but acknowledgement could riot be obtained because:

b Individual refused to sign O Communication barriers prohibited obtaining the acknowledgement

O An emergency situation prevented us from obtaining acknowledgement 0Other (please specify)

_____

110 Main St. SUite 1218 • Saco, ME 04072 • Phone (207)_ 284-4007 • Fax (207) 284-4096 • www.IslandPointDentistry.com