Paul J. Hubley, DMD & Associates

Cosmetic and Restorative Dentistry

Welcome to our dental office! We look forward to a long and healthy relationship.

OUR MISSION STATEMENT

Our goal is to provide exceptional, comprehensive dental care to our patients in a friendly and caring environment, while educating and encouraging them toward a state of optimal oral health. We are committed to continuing our education while sharing our knowledge with each other and our patients. We strive to work together as a team in order to respect every person's time and individuality. Our desire is for each patient to have a beautiful, healthy smile that will last a lifetime!

WHAT TO EXPECT

We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Your first appointment will be with one of our highly qualified and experienced hygienists. During this visit you will have your teeth cleaned, a periodontal charting and a full series of x-rays (if one has not been provided) completed. Your next visit is a comprehensive exam with either Dr. Hubley or Dr. Coletti. It is during this session that your doctor will explain the purpose of your recommended treatment and together a formulated treatment plan will be devised.

PAYMENT AND FINANCING

For your convenience we take Cash, Personal Checks, Major Credit Cards, and CareCredit. We are in network with Delta Dental Premier Plan and BCBS of MA Dental Blue Plan only, but as a courtesy we will submit to all insurance companies. Unfortunately, this office does not extend long term payment plans in house, however the office offers CareCredit for that purpose. We wish to dedicate our time to helping our patients achieve their goals by providing the very best dental care that they want, need and have come to expect. In order to achieve this, we ask that our patients compensate the dentist for his time and experience at the time the services are rendered (less anticipated insurance payment). If you have questions regarding fees or insurance coverage, the front desk staff will be happy to speak with you.

BROKEN AND LATE CANCELLATIONS

We do ask that when you make an appointment that you check your calendar(s) to make sure that the time you request will work for you. We ask that 48hr notice is given to change or cancel a scheduled appointment. We reserve the right to charge for cancelled or no-show appointments.

PATIENT – DOCTOR EXPECTATIONS

Before we get started with any treatment we would like to tell you a little about our approach at. The Cinamon & Hubley Dental Practice. We love seeing new patients and you are at the right office! There are many benefits to being a patient in our office and I'd like to point out our very specific benefits:

1) You can be expected to be treated like family. We like to think of our office as a big extended family. As a patient here you can expect the doctors to treat you exactly as they would treat any of their family or loved ones.

2) We provide state-of-the-art care. This office uses the highest quality materials, dental laboratories, equipment, and we pride ourselves and our team on taking the latest courses on dental advancements so that you can receive the highest quality dental care available today. The quality of care you receive here is our highest priority and you will be thrilled with the care you receive.

3) We stand behind our treatment. Should you require any treatment, we will provide you with our "warranty" of that treatment. If anything does not meet your standards or our standards, we will happily replace it at no cost to you. If any treatment is recommended, we will go over the "warranty" with you.

4) Emergency care after hours. As an active patient of our office, you can expect to reach Dr. Hubley or Dr. Coletti, after hours, for emergency care. You will receive our business card with the practice phone number highlighted and explain that if you ever need to reach Dr. Hubley and Dr. Coletti after hours, for an emergency, all you have to do is call the office number. We ask that if it is not urgent you call the office during regular business hours.

Now that you know what you can expect from us, we would like to take a moment to explain what we expect from you. It's very simple, really. Just one thing, if you make an appointment, we expect you to arrive on time. Now, we fully understand that things can happen and if it ever happens that you need to reschedule an appointment, we kindly ask that you give us at least 48 hours' notice so that we can schedule another deserving patient.

We do reserve the right to charge for late cancellations or no-show appointments.

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PATIENT INFORMATION

NAME_____ D.O.B. _____ DATE _____

ADDRESS_____ APT # ____ CITY/TOWN_____ZIP __ ____

HOME PHONE_____ WORK PHONE_____CELL _____

E-MAIL ADDRESS_____ Social Security_____

EMERGENCY CONTACT NAME:_____ _ PHONE_____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE COMPANY NAME: _____

NAME OF SUBSCRIBER_____D.O.B_____

SUBSCRIBER ID#_____ GROUP# _____

EMPLOYER:_____

SECONDARY DENTAL INSURANCE COMPANY NAME:_____

NAME OF SUBSCRIBER_____D.O.B_____

SUBSCRIBER ID#_____GROUP#_____

EMPLOYER_____

Responsible Party

Person responsible for this account_____

Address_____

Home phone_____ Cell phone_____

PATIENT DENTAL HISTORY

Name of previous dentist _____Phone number_____

Date of Last Exam or Visit_____

Please circle (Y) Yes or (N) No to the statements below.

Y N	My gums bleed while brushing or flossing.	**Y N**	I have frequent headaches.
Y N	My teeth are sensitive to hot or cold liquids/foods.	**Y N**	I clench or grind my teeth.
Y N	My teeth are sensitive to sweet or sour liquids/foods.	**Y N**	I bite my lips or cheeks frequently.
Y N	I experience pain in my teeth.	**Y N**	I have difficulty with extractions.
Y N	I have sores or lumps in or near my mouth.	**Y N**	I have/had orthodontic treatment
Y N	I have head, neck or jaw injuries.	**Y N**	I wear dentures and/or partials.
Y N	I experience the following: Clicking____ Difficulty in chewing____ Pain-joint, ear, side of face____ Difficulty in opening or closing____	**Y N**	I like my smile.

223 Walnut Street, Suite 6, Framingham, MA 01702

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MEDICAL HISTORY

PCP Name_____Phone#_____

1. Are you under medical treatment? __yes __no

If yes, please explain_____

2. Have you been hospitalized for any reason within the last 5 years? __yes __no

If yes, Please explain_____

3. Have you taken the diet drug Fen-Phen or Redux? ___yes ____no
4. Have you taken any bisphosphonates (Fosamax, Boniva, Actonel) ___yes ___no
5. Do you use tobacco? ___yes ___no
6. Do/have you use/d any controlled substances? ___yes ___no Explain:_____
7. Do you wear contact lenses? ___yes ___no
8. Do you have a persistent cough or throat clearing issue not related to a known illness? ___yes ___no
9. DO YOU PREMED/ANTIBIOTICS FOR DENTAL APPOINTMENTS? ___yes ___no
10. EPINEPHRINE SENSITIVITY? ___yes ___no
11: WOMEN ONLY: Are you pregnant? ___yes ___no: Nursing ___yes ___no:
Are you taking oral contraceptives? ___yes ___no

12: **PLEASE PUT A CHECK MARK IF YOU HAVE ANY OF THE FOLLOWING ALLERGIES**?

AMPICIL/AMOXICILLIN_____ LOCAL ANESTHETICS_____ ASPIRIN_____ BACTRIM _____
CODEINE_____ ERYTHROMYCIN_____ KEFLEX_____ LATEX_____ METALS_____
PENICILLIN _____ SULFA DRUGS_____ TETRACYCLINE_____
ANY OTHER NOT LISTED ABOVE_____ NONE OF THE ABOVE_____

13: PLEASE PUT A CHECK MARK IF YOU HAVE OR HAD ANY OF THE FOLLOWING:

AIDS/HIV_____	HAY FEVER/SEASONAL ALLERGIES_____	MULTIPLE SCELROSIS_____
ACID REFLUX____	HEART ATTACK_____	MUSCLAR DYSTROPHY _____
ANEMIA_____	HEART DISEASE_____	PARKINSON DISEASE_____
ANGINA_____	HEART MUMUR-_____	PSYCHIATRIC CARE_____
ALZHEIMERS/DEMENTIA_____	HEART OTHER_____	
ARTHRITIS_____	HEPATITIS _____	RADIATION/CHEMO THERAPY ____
ASTHMA____	HIGH BLOOD PRESSURE_____	RESPITATORY/LUNG PROBLEMS ____
AUTISM/RELATED DISABILITY____	JOINT REPLACEMENT_____	RHEUMATIC OR SCARLET FEVER_____
CANCER_____	KIDNEY DISEASE_____	SEXUALLY TRANSMITED DISEASE____
CARDIAC PACEMAKER_____	OSTEOPOROSIS ___	STROKE _____
DIABETES____ INSULIN_____	LEUKEMIA_____	THYROID PROBLEMS/DISEASE/CANCER_____
DRY MOUTH_____	LIVER DISEASE_____	TUBERCULOSIS_____
EPILEPSY_____	LOW BLOOD PRESSURE_____	ULCERS_____
FAINTING/SEIZURES _____	LUPUS/AUTOIMMUNE DISEASE___	SUBSTANCE ABUSE___EXPLAIN BELOW**
GLAUCOMA_____	MITRAL VALVE PROLAPSE_____	**NONE OF THE ABOVE**_____

Any other medical conditions not listed:_____

_____

__

**_____

MEDICATIONS: PLEASE LIST BELOW ANY MEDICATIONS YOU ARE CURRENTLY TAKING (PRESCRIPTION AND OR OVER THE COUNTER SUPPLEMENTS):_____

223 Walnut Street, Suite 6, Framingham, MA 01702

Authorization and Release:

Pertaining to the above Patient Information and Medical History:
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize and request my insurance company to pay the dental office directly. I will be responsible for the balance not covered by the insurance company and/or any outstanding balance on my account for services rendered.

SIGNATURE OF PATIENT (or parent/guardian if a minor):

_____ Date_____

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OUR FINANCIAL POLICY

Patient Name: _____ Date: _____

Our provision of care to you will result in a bill for our services. Following is a statement of our financial policy, which we request you read and sign prior to your treatment. In addition all insured patients must provide insurance information before seeing the dentist.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE, UNLESS WE ARE BILLING YOUR INSURANCE FOR YOU, IN WHICH CASE, ANY APPLICABLE CO-PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECK, MAJOR CREDIT CARDS AND CITIHEALTH CARD. WE DO NOT OFFER IN-HOUSE PAYMENT PLANS.

REGARDING INSURANCE

We ask that you show your dental insurance card at time of each visit so we can set up or update the correct billing information. As a courtesy we will bill your insurance carrier for the charges which the insurance company has agreed to pay. You are responsible for any amounts not covered by your insurance. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If the office is not informed of specialist work (i.e. Endodontics, Periodontics, Oral Surgery) done or guidelines in your policy, such as pre-authorizations, missing tooth clause, covered and non-covered services, and we subsequently preform services that are not covered we will have to bill you directly for those charges. If your insurance company has not paid your account within 45 days, the account automatically becomes your responsibility and will become due immediately. Please be aware that some of the services provided may not be covered or may not be approved for payment under your policy, but have been deemed to be in your best interest by your dentist.

RESPONSIBILITY

If you are 18 or older, you are legally responsible for your own account, regardless of who you come with, who has a contract with an insurance company or who claims you as a tax deduction. If the patient is under 18, both parents, despite divorce or other separation arrangements, or the legal guardian of the patient, are responsible for payment.

I have read the Financial Policy and understand its terms.

Signature of patient or guardian:_____Date:_____

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HIPAA REGULATIONS FORM

SECTION A: PATIENT GIVING HIPAA/CONSENT

Name: _____ Date: _____

Address: _____ Telephone: _____

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 may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to 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:

HIPAA Manager: Louise Lucas, 223 Walnut St, Ste 6, Framingham, MA 017102

I, _____, (Please Print) 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 healthcare operations.

Signature: _____ D ate: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

REVOCATION OF CONSENT: I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations .I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.

Signature_____Date_____

Office use only: (We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because) Please check one of the following: _____Individual refused to sign _____Communication barriers prohibited obtaining acknowledgement _____An emergency situation prevented us from obtaining acknowledgement _____ Other____

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Patient Name: _____

Date: _____

HOW DID YOU HEAR ABOUT US?

Please put a check mark next to all that apply.

- Yellow Pages / Phone Book
- Insurance Company List: _____
- Family/Friend Referral: _____
- Google Search / Internet Search
- The Framingham Source
- 1-800-DENTIST
- Our Website
- Facebook – if not, follow us today Cinamon & Hubley (with tooth logo)
- Instagram – if not, follow us today @cinamonhubleydentists
- Drive by / saw sign
- My Employer (please specify): _____
- Other (please specify): _____