Dr. LeeAnn Cote – Dr. C.J. Thomas
Dr. Rachel Garoufalis – Dr. Richard Flynn

HEALTH HISTORY

Patient's Name_____

Address:_____ **City:**_____**State:**_____ **Zip:** _____

Birth Date: _____ **Cell Phone**:_____

Home Phone:_____**Work Phone**: _____ **Ext.**_____

General Dentist:_____**Referred By (same [ ])**:_____

Physician:_____ **Phone:**_____

In case of an emergency, contact:_____**Phone:**_____

Please circle YES or NO below. Your answers are confidential and necessary to treat you properly.

YES NO Are you in good health?

YES NO Have you had any serious illness, operation or been hospitalized in the last five years?

YES NO Are you taking any of the following medications? If yes, which one(s):
YES NO Antibiotics?_____
YES NO Blood thinner/Aspirin therapy?_____
YES NO High blood Pressure or Heart medications?_____
YES NO Pain Medications?_____
Please List Other Medications: _____

Are you allergic to or had adverse reactions from any of the following? If yes, please describe:
YES NO Local Anesthetics?_____
YES NO Latex?_____
YES NO Penicillin or any other antibiotic?_____
YES NO Codeine or other Narcotics?_____
YES NO Others?_____
YES NO Have you ever had asthma? If yes, when was your last attack?

YES NO Do you use any recreational drug? If yes, was last use in 24 hours?

YES NO Do you or have you ever suffered from drug or alcohol addiction?

YES NO Do you have a damaged or prosthetic heart valve, surgically constructed shunt/ conduit, mitral valve prolapse, or a heart murmur?

YES NO Have you ever had rheumatic fever, rheumatic heart disease, bacterial endocarditis, cardiomyopathy, or a congenital heart defect?

Continues on next page

YES **NO** Have you ever suffered from angina, a heart attack, or an irregular heart rhythm?

YES **NO** Do you have a pacemaker?

YES **NO** Have you ever had a TIA or stroke?

YES **NO** Do you have an artificial joint prosthesis? If yes when was it placed?

YES **NO** Do you have diabetes? If yes, do you take insulin?

YES **NO** Have you ever had jaundice, hepatitis, cirrhosis, or liver disease?

YES **NO** Have you ever had a kidney disorder?

YES **NO** Have you ever had stomach ulcers, or colitis?

YES **NO** Do you ever have arthritis?

YES **NO** Do you have a thyroid disorder?

YES **NO** Have you ever had chemotherapy, radiation, or surgery for a cancer or tumor?

YES **NO** Do you have or have you ever had HIV, tuberculosis, or any other contagious disease?

YES **NO** Do you have any bleeding problems or blood disorders?

YES **NO** Do you have epilepsy or a seizure disorder?

YES **NO** Do you have a sinus problem?

YES **NO** Have you ever suffered from a TMJ disorder or other jaw joint problems?

YES **NO** Do you have any numbness, tingling or altered sensation in or around your mouth?

YES **NO** Do you have or have you been treated for bone cancer that originated from other sites (such as breast, lung, prostate, etc)?

YES **NO** Do you have or have you been treated for osteoporosis, osteopenia, Paget's disease, or multiple myeloma?

YES **NO** Are you taking or have you taken any of the following medications: Fosamax (alendronate), Zometa (zoledronate), Aredia (pamidronate), Actonel (risedronate), Boniva (ibandronate), Skelid (tiludronate), Bonefos/ Ostec (clodronate), Didronel (etidronate)?

YES **NO** Are you taking an oral contraceptive?

YES **NO** Are you pregnant?

YES **NO** Are you nursing?

If you have any condition or problem not listed above that you think your doctor should know about, please describe it here:

Patient Signature:_____ Date: _____

Doctors Signature:_____ Date: _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

You May Refuse to Sign This Acknowledgment

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining acknowledgment
- ☐ An emergency situation prevented us from obtaining Acknowledgment
- ☐ Other (please specify)

_____
_____
_____

Please continue on reverse side

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HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ DOB:_____

Name of parent or guardian (if different than patient): _____

I authorize disclosure of information regarding my/my spouse or domestic partner/my dependent's billing, condition, treatment and prognosis to the following individual(s) (please add caregivers that may accompany children to appointments):

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

Voice & Text Messages
Please call/text ( ) my home ( ) my work ( ) my cell number: _____

If unable to reach me:
( ) you may leave a detailed message
( ) please leave a message asking me to return your call

Signed: _____ Date: _____/_____/_____

Parent/Guardian:_____ Date: _____/_____/_____

FINANCIAL

Since most of our endodontic specialty care is completed in one visit, all fees are due at the time of treatment. As a courtesy to our patients who have dental insurance, our reception staff will inquire about your eligibility, benefits availability and deductible. **We will estimate your co-payment which is due at the time of treatment.** You will receive a bill for any remaining balance. If there is an overpayment, we will promptly issue a refund check. Ultimately, a patient is responsible for their account; not their insurance company. Please feel free to ask our staff any insurance related questions.

Patient or Parent/Guardian Signature

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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 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 07/16/2026 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use your contact information to send you reminders and contact you about your health care operations as described below:

- Communications to describe health-related products or services, or payment for them, provided by or included in a benefit plan of the covered entity making the communication;
- Communications about participating providers in a provider or health plan network, replacement of or enhancements to a health plan, and health-related products or services available only to a health plan's enrollees that add value to, but are not part of, the benefits plan;
- Communications for treatment of the individual; and
- Communications for case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or care settings to the individual. No contact or patient information will be shared with third parties or affiliates for marketing or promotional purposes. Any communications and contact information sharing will follow HIPAA policies. Please refer to the hhs.gov website for detailed information.

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 as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections 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 a specialist providing treatment 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 may use and disclose your health information in connection with our healthcare operations. 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; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 laws.

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 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. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

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 care 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 (e-mail).

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 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.

Telephone: (207)-494-7301
Fax: (207)571-4823
Address: 6 Wellspring Rd, Suite 105 Biddeford, ME 04005
28 Long Sands Rd, Suite 4 York, ME 03909
E-mail: info@southernmaineendo.com