WELCOME TO ELEVATE DENTAL

In scheduling your first appointment you have taken the first step to achieving optimal dental health. There is one very important aspect of our philosophy, you must "choose" to become healthy. We will guide and coach you by sharing information and allowing you to make an informed decision. The core of our philosophy is being pro-active and preventing dental disease, rather than re-active.

We provide comprehensive care and believe that oral health affects the entire body and overall wellness. Our treatment philosophy is based upon conventional medicine, science and evidence-based practice.

Together we will explore and examine your teeth, gums, joints and create a lifetime treatment plan. Dr. Kristen or Dr. Mike will recommend needed diagnostics, scans and pictures of your teeth. We will review your past dental history, records and x-rays in order to obtain a comprehensive understanding of your personalized needs. With these tools we can determine your present state of dental health and recommend an individualized treatment plan.

In order to maximize your dental benefits, please bring in your insurance information. In order to answer all of your questions, we have put aside an hour and a half for your visit.

TIME 03:00 PM DATE 1/18/2023

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Contact Person

credit card number

exp date

date last updated

security code

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

MEDICAL HISTORY

Patient Name: _____ Birth Date: _____ Date: _____

Primary Care Physicians Name: _____ Phone #: _____

Have you been hospitalized or had major operation? Yes ◯ No ◯ If yes_____

Have you ever had a serious head or neck injury? Yes ◯ No ◯ If yes_____

Are you taking any medications? Please list with dosages (including vitamins, herbs etc.)

_____

_____

_____

Do you take, or have you taken Phen-Fen or Redux? Yes ◯ No ◯

Have you ever taken Bisphosphonates* Yes ◯ No ◯ *Examples: Fosamax, Boniva, Actonel

Are you on a special diet? Yes ◯ No ◯

Do you use tobacco? Or have a history or smoking? Yes ◯ No ◯

Are you advised to take Pre-med by physician? Yes ◯ No ◯ If yes, what do you take? _____

Women: Are you…… Pregnant ◯ Nursing ◯ Taking oral contraceptives ◯

ALLERGIES: Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯

Metal ◯ Latex ◯ Sulfa Drugs ◯ Local Anesthetics ◯

Allergies not listed above: _____

Do you use controlled substances or recreational drugs? Yes ◯ No ◯ If yes, _____

Do you have, or have you had, any of the following? Check off either Y (yes) or N (no) below.

	Y	N		Y	N		Y	N		Y	N
AIDS/HIV Positive			Cortisone medicine			Hemophilia			Radiation treatment		
Alzheimer's			Diabetes			Hepatitis A			Recent weight loss		
Anaphylaxis			Drug Addition			Hepatitis B or C			Renal dialysis		
Angina			Easily Winded			Herpes (lip or mouth)			Rheumatic fever		
Arthritis/gout			Emphysema			High Blood pressure			Scarlet fever		
Artificial heart valve			Epilepsy or seizures			High Cholesterol			Shingles		
Artificial joint			Excessive Bleeding			Hives or Rash			Sickle cell disease		
Asthma			Excessive Thirst			Hypoglycemia			Sinus trouble		
Blood disease			Fainting spells/dizzy			Irregular heartbeat			Spina bifida		
Blood transfusion			Frequent Cough			Kidney problems			Stomach/intestinal disease		
Breathing Problems			Frequent Diarrhea			Leukemia			Stroke		
Bruise Easily			Frequent Headaches			Liver disease			Swelling of limbs		
Cancer			Genital Herpes			Low blood pressure			Thyroid disease		
Chemotherapy			Glaucoma			Lung disease			Tonsillitis		
Chest Pains			Hay Fever			Mitral valve prolapse			Tuberculosis		
Cold Sores			Heart attack/failure			Osteoporosis			Tumors or growths		
Congenital heart disorder			Heart Murmur			Pain in jaw joint			Ulcers		
Convulsions			Heart pacemaker			Parathyroid disease			Veneral disease		
Yellow Jaundice			Sleep Apnea			Psychiatric care			Blood thinner		
Human Papilloma Virus (HPV)			ADD/ADHD			Use of C-PAP			Autism/Asperger syndrome		
Multiple Sclerosis											

Med. Hx Continued….

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

Have you been told you needed to have a sleep study? Yes ◯ No ◯ If yes _____

If yes to cancer, what type of cancer, when? _____

_____

_____

If yes to chemo/radiation, if so when? How many Grays (Gy) have you been exposed to?

_____

_____

Comments:

_____

_____

_____

To the best of my knowledge, the questions on his form have been accurately answered. I understand that providing incorrect information or leaving out information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical history at each visit.

Signature of Patient, Parent or Guardian

X _____ Date _____

DENTAL UPDATE QUESTIONNAIRE

Name _____ Date:_____
Are you experiencing any discomfort? _____ If yes explain_____
Does dental treatment make you nervous? _____
Date of last dental visit _____ Date of last dental cleaning _____
Have you ever been treated for gum disease?_____
How often do you brush? _____ Type of tooth brush: manual ◯ electric ◯ Do you floss? _____
Do you wear a mouthguard made by a dentist at night? _____

Please check off if you have or ever had any of the following:

MOUTH
◯ Bleeding sore gums
◯ Unpleasant taste/bad breath
◯ Burning tongue/lips
◯ Frequent blisters
◯ Swelling/lumps
◯ Clicking or popping jaw
◯ Difficulty opening/closing
◯ Braces or Invisalign

TEETH
◯ Loose teeth
◯ Sensitivity to hot
◯ Sensitivity to cold
◯ Sensitivity to sweets
◯ Sensitivity to biting
◯ Food catching between teeth
◯ clenching or grinding, if so when…. ◯ daytime ◯ nighttime
◯ shifting in bite

Is there anything you would like to change about your smile? _____
What things are most important to you about your dental health? _____
Have you lost any teeth? _____ if so, have they been replaced? _____ if not, why? _____
Are you unhappy with the replacements? _____ if so why? _____
Would you be interested in learning more about replacements? _____
Do you have any difficulty getting numb? _____ if yes explain _____
Have you experienced any problems or complications with previous dental treatment? If yes, please explain.
_____

Please circle your answer to the following 7 statements:

1.) My mouth is a.) very comfortable b.) moderately comfortable c.) uncomfortable

2a) I think the appearance of my mouth is excellent
2b) I am satisfied with the appearance of my mouth
2c) I am disappointed with the appearance of my mouth

3a) I have set goals for my oral health with a previous dentist
3b) I want to set goals concerning my dental health

4a) I have put dentistry for myself and family high on priority list completed
4b) I have put dentistry for myself and my family low on priority list
4c) I have dentistry on my list, but its hard to find

5a) I will do anything to keep my natural teeth
5b) I want to keep my teeth, but have a budget of time and money I am willing to spend
5c) I expect I will lose most/all of my teeth like my parents did

6a) I have always done the best recommended for my dental health
6b) I have not done what dentists have recommended to me
6c) I rarely go and don't care about having any dental work

7.) I think my present state of dental health is a.) excellent b.) good c.) poor
What are some questions about dentistry that you have never had adequately answered? _____
_____

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369 Heineberg Drive, Colchester, VT 05446
P: 802-658-4873
info@elevatedentalvt.com

RECORDS RELEASE FORM

I, (print full legal name), _____, on (date)_____, give permission to the office of (indicate below) to release my records:

- _____ (**transferring to** Elevate Dental)
- _____**Elevate Dental** _____ (**transferring from** Elevate Dental)

Additional Office Information:

Address: _____

Phone: _____

Email: _____

Additional Comments / Reason for Transfer: _____

Additional dependents (children under 18) to release records to the same office as noted above:

_____

_____

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

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Financial, Insurance and Appointment Policy

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from responsibility for the payment of all charges.

Insurance Assignment and Release

I certify that I and/or my dependent(s) have insurance coverage with company above and assign directly to Elevate Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all the charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. Liscio dental may use my healthcare information and may disclose such information to the above insurance company or companies and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Commitment to Appointments

For the benefit of our patients, we work with one patient at a time. (We reserve a time for each patient separately.) When you make an appointment, it is a bond of trust that we will be here to serve you and you will in turn, be here at the scheduled time. Please be present for your scheduled appointments. In this way, we can serve your dental needs. We ask that on the rare occasion you need to cancel or change appointment you give us a 48-hour notice or 2 business days. If your appointment is broken or canceled without a 48-hour notice, a $75 fee may be assessed to your account for any hygiene related appointment, and $125 for a doctor related appointment.

Please sign below to indicate you understand and agree to all of the policies and statements above.

Patient Signature _____

Print Name _____ Date _____

Kristen Gibilisco DMD FAGD FICOI & Michael Gibilisco DMD
369 Heineberg Dr., Colchester, VT 05446
802.658.4873 // elevatedentalvt.com

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Authorization to Charge Credit/Debit Card

To authorize a one-time or recurring charge to your credit card for treatment services rendered, please complete and sign this form. We adhere to the highest standards for account data protection.

Patient Billing Information

Patient Name: _____

If patient under 18 years of age, Guardian's Name: _____

Billing Address: _____

City_____ State: _____ ZIP: _____

Phone: _____

E-mail: _____

Credit Card Type: __Visa __MasterCard __American Express __Discover

Cardholder Name (on credit card): _____

Credit Card #: _____ Expiration: _____ Security Code: _____

I hereby authorize Elevate Dental to charge my credit card above in the amount of $45 for on any occasion in which I fail any Hygiene related appointment at Elevate Dental, and $125 for any Doctor related appointment. This is a one-time charge authorization. I am not authorizing Elevate Dental to set up my account for recurring billing. I understand all cancellations regarding my account must be in writing. I guarantee that I am the legal cardholder for this credit card account and that I am legally authorized to use it.

Signature of Cardholder: _____ Date: _____

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ELEVATE DENTAL Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of ELEVATE DENTAL ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact ELEVATE DENTAL'S Privacy Official at:

369 HEINEBERG DRIVE, COLCHESTER, VT 05446

802-658-4873

802-863-5400

INFO@ELEVATEDENTALVT.COM

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on February 15, 2022.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

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1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

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6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

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If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to

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these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is 2/15/2022.

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

Notice of Privacy Practices

Consent for Use and Disclosure of Health Information

Patient Information

First Name _____ **MI** _____

Last Name _____

Address _____

Phone Number _____

Email _____

Kristen Gibilisco DMD FAGD FICOI & Michael Gibilisco DMD
369 Heineberg Dr., Colchester, VT 05446
802.658.4873 // elevatedentalvt.com

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SS# _____

Signing below, I have thoroughly read Elevate Dental's Notice of Privacy Practices and understand how my medical information may be used and disclosed and also how I am able to get access to my medical information.

Patient Signature: _____Date _____

Please initial each statement below:

_____ I understand and acknowledge my rights as detailed in the Notice of Privacy Practices Presented here.

_____ I understand and consent to my medical information being used as described here.

_____ I understand the terms and authorize the practice to disclose my medical information to those parties as mentioned here.

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