Quiet Corner Dental

Carolyn E. McGinn, D.M.D. • Walter P. McGinn, D.M.D
Eleni Milas, D.M.D.

153 Grove Street
Putnam, CT 06260
(860) 928-3723

quietcornerdental.com

Welcome!

Thank you for choosing us to be a partner in caring for your dental health! We look forward to seeing you. Our goal is to make your visits as pleasant and efficient as possible. You can assist the process by completing and returning the enclosed health registrations. The enclosed "Request for Dental Records" form should be sent to your previous dentist(s) as soon as you receive it. Having prior records available at the initial visit can be very helpful.

An initial exam includes an oral examination by one of the dentists and a radiographic (x-ray) examination. If you have had dental x-rays in the past, please make arrangements to have them transferred to our office, as mentioned above. Your examination is not complete without full x-ray information.

We will assist you with the insurance claims process. Dental insurance may not cover the total cost of your treatment. Your payment is usually expected when treatment is delivered. If your insurance company fails to pay within 60 days after we submit your claim, you will be responsible for the full fee.

Again, we look forward to seeing you soon! Please give me a call if I can be of any assistance.

Best Wishes,
Quiet Corner Dental Team

Medical History Date:_____

Do you now have or have you ever had any of the following:

	Yes	No	Don't know
Bleeding disorders, anemia.....	___	___	___
Diabetes.....	___	___	___
Liver disease, hepatitis.....	___	___	___
Prosthetic heart valve, cardiac transplantation.....	___	___	___
Congenital heart disease, endocarditis.....	___	___	___
Heart Disease, Pacemaker.....	___	___	___
High blood pressure.....	___	___	___
Prosthetic replacement of any joint.....	___	___	___
Arthritis.....	___	___	___
Lupus.....	___	___	___
Immunosuppression.....	___	___	___
Radiation treatment.....	___	___	___
Chemotherapy.....	___	___	___
Sinus disease.....	___	___	___
Allergy to any medicines.....	___	___	___
Allergy to any antibiotics.....	___	___	___
Osteoporosis treated with medication	___	___	___
Medical condition requiring hospitalization.....	___	___	___
Medical condition treated by your physician.....	___	___	___
Do you use any form of tobacco?	___	___	___
Have you ever used any form of tobacco?	___	___	___

Please answer these questions. Use the space below if you need more.
Please list any medicines you are taking._____
Have you ever taken a bisphosphonate medication such as: Boniva, Fosamax, Zometa, Didronel, Skelid, Actonel, Aredia? If yes please circle the medicine.
Have you ever been hospitalized? If so, for what?_____
Are you receiving treatment from your physician? If so, for what?_____
Who is your physician? Where is the office?_____
What is the reason for your visit?_____

Signature:_____Date:_____

Please complete both sides.

Adult Registration

Today's Date:_____

Name:_____

Birthdate:_____Age:_____Male:_____Female:_____

Spouse's Name:_____

eMail Address:_____

Mailing Address:_____

City:_____State:_____Zip:_____

Phone-home:_____Phone-work:_____Phone-Cell:_____

How would you prefer to be contacted for appointment confirmation?

___Phone ___Text ___Email

Who will pay this account ?_____

In case of emergency provide the name and phone number of someone not at your home whom we might contact._____

Insurance Information

Please provide name and date of birth of insured person if it differs from information above:_____

Name and address of dental insurance company:

_____

_____

Policy#: _____

Employer/Plan Sponsor: _____

19. **I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.**

X _____ _____

Signed (Patient* – see reverse) Date

20. **I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.**

X _____ _____

Signed (Employee/subscriber) Date

Insurance companies require that we obtain the above signatures to process your claims even though we submit almost all claims electronically. Signing above allows us to send paperless information to the insurance company about your visit. If this is your first visit this might include: an initial exam (D0140), x-rays (D0210, D0330 or D0274).

You avoid the inconvenience of waiting for the insurance company to reimburse you for services by allowing the insurance company to pay directly to us.

Please send this form to your previous dentist.

Carolyn E. McGinn, DMD
Walter P. McGinn, DMD
153 Grove Street
Putnam, CT 06260
(860) 928-3723
putnamdentist@icloud.com

Request for Dental Records

To: _____

_____

_____

_____

Dear Doctor,

Please send copies of dental records and radiographs for the individuals listed below to Dr. McGinn, 153 Grove Street, Putnam, CT 06260 or **putnamdentist@icloud.com**.

Print name	D.O.B	Relationship	Signature/date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Thank you for your assistance.

Carolyn E. McGinn, D.M.D.
Walter P. McGinn, D.M.D.
153 Grove Street
Putnam, CT 06260
(860) 928-3723

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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 APRIL 14, 2003, 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 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 will charge you $0.25 for each page, $25.00 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 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.
Contact Officer: Walter McGinn, D.M.D.
Telephone: (860) 928-3723
Fax: (860) 928-0029
E-mail: wpmcginn@mac.com
Address: 153 Grove Street, Putnam, CT 06260

Carolyn E. McGinn, D.M.D.
Walter P. McGinn, D.M.D.
153 Grove Street
Putnam, CT 06260
(860) 928-3723

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

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

_____
Please Print Name

_____
Signature

_____
Date

For Office Use
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
_____Individual refused to sign
_____Communications barriers prohibited obtaining the acknowledgement
_____An emergency situation prevented us from obtaining acknowledgement
_____Other (Please Specify)

Date:_____

Signature:_____

Directions

Our office is located at 153 Grove Street (Route 12) in Putnam (928-3723).

From Route 395 south (from Thompson) take exit 96. Turn right at the end of the ramp. Your destination is 5/10 of a mile on the left.

From Route 395 north (from Danielson, Dayville, Killingly) take exit 96. Turn left at the end of the ramp. The office is 6/10 of a mile on the left.

From the west and downtown Putnam (from Woodstock, Pomfret) follow Route 44 East (Pomfret Avenue) to its junction with Route 12 (at the railroad underpass). Turn right onto Route 12 south. 153 Grove Street is 6/10 mile ahead on the right.

Parking is available at the rear of the building. The reception room entrance is also at the rear of the building.

Appointment Policy

We strive to schedule patients to make the most efficient use of time and to remain on schedule. Patients can assist with this.

1. Please arrive on time for your appointment (even five minutes can make a difference). We will also do our best to seat you on time.

2. Children under 18 years of age must be accompanied by a parent or guardian who should plan to remain present in the office for the entire visit.

3. Please call the office in advance if family members wish to "swap" appointments (charts need to be reviewed and time allotments may be different).

4. Check up and cleaning appointments are scheduled six months in advance. If you cancel an appointment it may be difficult to reschedule it as soon as you may like. A call list is kept to fill cancellations. You may be asked if you wish to be included on this list if you cancel an appointment. If your schedule is flexible and you wish to be called you may find it helpful to be included.

We are doing our best to schedule our patients at the times and days requested. We appreciate your cooperation in this matter.