Thomas S Mulvey, DDS, LLC
Farisa S. Mulvey, DDS
148 Waterman Street
Providence, RI 02906
401-272-3443

Directions from:

Pawtucket	East Ave to Hope Street. Follow Hope Street to Waterman Street. Take a left onto Waterman Street. We are the 3rd building on the left.
North of Providence	Rt 95 South to Rt 195 East. Follow signs to Gano Street. Take a left at the end of the ramp. Follow to Gano take right onto Gano. Take a left onto Angell. At the first light take a left onto Hope and your first left onto Waterman Street. We are the 3rd brick building on the left.
East of Providence	Take 195 West to Gano Street Exit. At end of exit take a right onto Gano street. Take a left onto Angell Street a left onto Hope Street and a left onto Waterman. We are the 3rd building on the left.
South of Providence	Take 95 North to 195 East and follow the signs to Gano Street. Take a left at the end of the ramp. Follow to Gano take right onto Gano. Take a left onto Angell. At the first light take a left onto Hope and your first left onto Waterman Street. We are the 3rd brick building on the left.
East Providence/Henderson Bridge	Go over Henderson Bridge which brings you onto Angell Street. Follow Angell Street to the intersection of Hope Street and take a left. Take your first left to Waterman and we are the 3rd brick building on the left.

You do need to check your route in case an exit is closed on the day of your appointment. Please allow yourself plenty of time for detours or changes as well as daily traffic. If you are late for your appointment we may need to reschedule.

Please bring your insurance information to the office along with the enclosed completed forms on the day of your appointment. **(If you do not have a chance to fill out the forms then you will need to arrive *15 minutes prior* to your appointment time to complete them). If you do not have the correct insurance information at the time of the appointment, we may need to reschedule.**

Each 6 month recall visit in our office consists of an exam, fluoride treatment and cleaning. Please check your insurance to see if these services are covered twice a year.

It is important that you are on time for your appointment. Should you need to cancel or change an appointment, we ask that you give us at least 24 hours notice.

Should you have any questions, please feel free to call us at the above phone number.

Thank you,

Dr. Thomas S. Mulvey, D.D.S., L.L.C.
148 Waterman Street
Providence, RI 02906

Please complete both sides, *sign* and *date*.

BY SIGNING THIS FORM YOU ARE STATING THAT YOU ARE THE PARENT/LEGAL GURADIAN OF THIS CHILD.

This personal information is requested to enable us to give you the most consideration of your time and feelings. It is important to have complete answers so that we may give your child personal attention. This information is, of course, confidential. Thank You.

DATE FILLED OUT: _____

CHILD'S NAME _____ **Male___Female___AGE ____ DATE OF BIRTH** _____

CHILD'S SOCIAL SECURITY #_____ **PARENT'S E-MAIL** _____

ADDRESS _____ **CITY**_____ **ST**_____ **ZIP**_____

HOME PHONE_____ **CELL PHONE**_____

CHILD'S FAVORITE ACTIVITY_____ **SCHOOL**_____ **GRADE**_____

MOTHER / FATHER NAME_____ **DATE OF BIRTH** _____ **SS#**_____

WHERE DO THEY WORK?_____ **PHONE**_____ **OCCUPATION**_____

FATHER / MOTHER NAME_____ **DATE OF BIRTH** _____ **SS#**_____

WHERE DO THEY WORK?_____ **PHONE**_____ **OCCUPATION**_____

NAME OF CLOSEST RELATIVE_____ **Relationship**_____ **Phone**_____

Child's Physcian_____ **Address**_____ **Phone**_____

Date of last complete physical examination?_____ **Results**_____

MUST READ AND SIGN - LIST ALL ACTIVE *DENTAL* POLICIES:

WHO WILL BE RESPONSIBLE FOR THE ACCOUNT?_____ **DO THEY HAVE DENTAL INSURANCE?** _____

NAME OF PRIMARY DENTAL INS CO: _____ **SUBSCRIBER ID#** _____ **Group #** _____

SUBSCRIBER'S NAME_____ **Date of Birth:** _____ **(Please present card to receptionist.)**

NAME OF SECONDARY DENTAL INS CO: _____ **SUBSCRIBER ID#** _____ **Group #** _____

SUBSCRIBER'S NAME_____ **Date of Birth:** _____ **(Please present card to receptionist.)**

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ALL DENTAL SERVICES PROVIDED IN THIS OFFICE. PAYMENT IS DUE AT THE TIME THE SERVICE IS PROVIDED UNLESS OTHER ARRANGEMENTS ARE MADE.
I ALSO UNDERSTAND THAT ANY BALANCE NOT PAID BY MY INSURANCE CARRIER IS MY RESPONSIBILTY, AND IS DUE WHEN BILLED BY THIS OFFICE. ANY CLAIMS NOT PAID BY INSURANCE COMPANY WITHIN 60 DAYS BECOMES THE RESPONSIBILITY OF THE SUBSCRIBER UNLESS OTHER ARRANGEMENTS ARE MADE.
I UNDERSTAND THAT SINCE ALL INSURANCE POLICIES VARY, *IT IS MY RESPONSIBILTY* TO CHECK WITH MY INSURANCE CARRIER TO DETERMINE WHAT SERVICES ARE COVERED AND ANY LIMITATIONS THAT APPLY.

Signature of Parent/Guardian: _____

DENTAL HISTORY

DATE OF LAST DENTAL VISIT _____ **FOR WHAT?**_____ **BY DR**_____

DATE OF LAST X-RAYS: _____ **Please bring or have sent any x-rays taken in the past 12 months to avoid your being billed.**

ANY PREVIOUS UNHAPPY MEDICAL OR DENTAL VISITS? Yes No Explain:_____

HAS YOUR CHILD COMPLAINED ABOUT ANY DENTAL PROBLEMS/PAIN? Yes No Explain:_____
ANY INJURIES TO MOUTH, TEETH, HEAD? Yes No
ANY MOUTH HABITS–thumb sucking, nail biting? Yes No

CHILD'S ATTITUDE TO DENTISTRY?_____

Please Complete Reverse Side

MEDICAL HISTORY

All questions asked on the history form are important in arriving at a diagnosis and a treatment plan; all questions must be answered; if any question is not understood, it should be discussed with the doctor; if a medical condition not related to any question on the form is known, it should be reported to the doctor.

IS YOUR CHILD IN GOOD HEALTH? Yes No -If no please explain: _____

IS YOUR CHILD PRESENTLY UNDER CARE BY A PHYSICIAN? (Other than regular well visits) Yes No

If yes please explain:_____

IS YOUR CHILD RECEIVING ANY MEDICATIONS OR DRUGS? Yes No -If yes what are they?

_____

WHAT IS YOUR CHILD'S WEIGHT? _____HEIGHT _____

HAS YOUR CHILD EVER BEEN HOSPITALIZED? Yes No -If yes for what reason? _____

HAS YOUR CHILD EVER HAD SURGERY? Yes No -If yes for what reason? _____

HAS YOUR CHILD EVER HAD BLOOD TRANSFUSIONS? Yes No -If yes for what reason?_____

EATING HABITS PRESENTLY – BRIEFLY EXPLAIN _____

ARE THERE ANY PSYCHOLOGICAL OR EMOTIONAL PROBLEMS YOU WOULD LIKE TO BRING TO OUR ATTENTION? Yes No

-If yes for what reason? _____

DOES YOUR CHILD HAVE OR HAS HE/SHE HAD ANY OF THE FOLLOWING HEALTH PROBLEMS?	YES	NO
1) RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE	☐	☐
2) CONGENITAL HEART DISEASE OR HEART MURMUR	☐	☐
3) ALLERGIES: Please Specify	☐	☐
4) ASTHMA	☐	☐
5) ARTHRITIS OR RHEUMATISM (PAINFUL SWOLLEN JOINTS)	☐	☐
6) DIABETES OR BLOOD SUGAR PROBLEMS	☐	☐
7) ANY PROLONGED BLEEDING OR BRUISES EASILY	☐	☐
8) KIDNEY OR BLADDER PROBLEMS	☐	☐
9) ANEMIA OR BLOOD DISORDERS	☐	☐
10) TUBERCULOSIS OR PNEUMONIA	☐	☐
11) LIVER PROBLEMS, JAUNDICE OR HEPATITIS	☐	☐
12) AUTISM	☐	☐
13) GLANDULAR OR HORMONAL PROBLEMS	☐	☐
14) ACCIDENTS OR SEVERE INFECTIONS	☐	☐
15) CONVULSION, SEIZURES, FAINTING OR EPILEPSY	☐	☐
16) HIGH/LOW BLOOD PRESSURE	☐	☐
17) SPEECH, LEARNING OR HEARING DISORDERS	☐	☐
18) OTHER, IF SO EXPLAIN	☐	☐

"I UNDERSTAND THAT THE INFORMATION PROVIDED ON THIS FORM IS ESSENTIAL TO DETERMINE MY/MY CHILD'S DENTAL NEEDS AND THE PROVISIONS OF DENTAL TREATMENT. I UNDERSTAND THAT IF ANY CHANGE OCCURS IN MY/MY CHILD'S HEALTH THAT I AM TO REPORT IT TO THE DENTAL OFFICE AS SOON AS POSSIBLE. I HAVE READ AND DO UNDERSTAND EACH QUESTION AND HAVE ANSWERED ALL OF THE QUESTIONS TRUTHFULLY AND TO THE BEST OF MY ABILITY. I HAVE DISCUSSED MY HEALTH HISTORY WITH THE DOCTOR."

I hereby grant authority to: Thomas S. Mulvey, DDS, LLC, Thomas S. Mulvey, DDS and/or Farisa S. Mulvey, DDS of 1(Waterman Street, Providence, RI 02906 to administer any treatments and to perform such procedures as may be deemed necessary or advisable in the diagnosis and treatment of this patient only with the prior consent of either t parent or legal guardian.

_____ _____

SIGNATURE of Parent or Legal Guardian **Date**

THOMAS S. MULVEY, DDS, LLC
NOTICE OF HIPAA PRIVACY PRACTICE

This notice describes how health information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

Introduction

We are required by law to maintain the privacy of "protected health information." "Protected health information" includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care. As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a copy of our most current privacy notice from our office.

Permitted Uses and Disclosures

We can use or disclose your protected health information for purposes of treatment, payment and health care operations.

- Treatment means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Therefore, the doctor may review your medical records to assess whether you have potentially complicating conditions like diabetes.
- Payment means activities we undertake to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities. For example, prior to providing health care services, we may need to provide to your insurance carrier (or other third party payor) information about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the carrier or other third party payor for the services rendered to you, we can provide the carrier or other third party payor with information regarding your care if necessary to obtain payment.
- Health Care Operations mean the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what services are not needed, and whether certain new treatments are effective.

Disclosures Related To Communications With You Or Your Family

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you or relate specifically to your medical care through our office. For example, we may leave appointment reminders on your answering machine or with a family member or other person who may answer the telephone at the number that you have given us in order to contact you.

We may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the protected health information that is directly relevant to their involvement in your care. We will allow your family and friends to act on your behalf to pick up prescriptions, medical supplies, X-rays, and similar forms of protected health information, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.

Other Situations

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the Armed Forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report victim of abuse, neglect, or domestic violence
- To report reactions to medications
- To notify people of product, recalls, repairs or replacements
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition

Health Oversight Activities. We may disclose medical information to federal or state agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. We may disclose protected health information to persons under the Food and Drug Administration's jurisdiction to track products or to conduct post-marketing surveillance.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in a response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process
- To identify or locate a suspect, fugitive, material witness, or missing person
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of a criminal conduct
- About criminal conduct on our premises
- In emergency circumstances to report a crime; the location of the crime or victims or the identity, description or location of the person who committed the crime

Coroners, Medical Examiners and Funeral Directors. We may release medical information 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 release medical information about patients to funeral directors as necessary to carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.
Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use of disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
Disaster Relief. When permitted by law, we may coordinate our uses and disclosures of protected health information with public or private entities authorized by law or by charter to assist in disaster relief efforts.

Your Rights

1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request.
2. You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations.
3. Subject to payment of a reasonable copying charge as provided by state law, you have the right to inspect or obtain a copy of the protected health information contained in your medical and billing records and in any other practice records used by us to make decisions about you, except for:
   - Psychotherapy notes, which are notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record
   - Information compiled in a reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.
   - Protected health information involving laboratory tests when your access is required by law
   - If you are a prison inmate and obtaining such information would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you
   - If we obtained or created protected health information as part of a research study for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research
   - Your protected health information is contained in records kept by a federal agency or contractor when your access is required by law
   - If the protected health information was obtained from someone other than us under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information

   We may also deny a request for access to protected health information if:
   - A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person
   - The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person
   - The request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person

   If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law.
4. You have the right to request a correction to your protected health information, but we may deny your request for correction, if we determine that the protected health information or record that is the subject of the request:
   - Was not created by us, unless you provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment
   - Is not part of your medical or billing records
   - Is not available for inspection as set forth above
   - Is not accurate and complete

   In any event, any agreed upon correction will be included as an addition to, and not a replacement of, already existing records.
5. You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you for the period provided by law, except for disclosures:
   - To carry out treatment, payment and health care operations as provided above
   - To persons involved in your care or for other notification purposes as provided by law
   - For national security or intelligence purposes as provided by law
   - To correctional institutions or law enforcement officials as provided by law
   - That occurred prior to April 14, 2003
   - That are otherwise not required by law to be included in the accounting
6. You have the right to request and receive a paper copy of this notice from us.
7. The above rights may be exercised only by written communication to us. Any revocation or other modification of consent must be in writing delivered to us.

Complaints

If you believe that your privacy rights have been violated, you should immediately contact our Practice or our Privacy Officer. All complaints must be submitted in writing. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

Privacy Contact: Telephone: (401)272-3443 Fax: (401)272-3539
Address: 148 Waterman Street, Providence, RI 02906

THOMAS S. MULVEY, DDS, LLC
FARISA S. MULVEY, DDS

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 ONLY

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)