Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex:

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY

	Yes	No	DK
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

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Form S500

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question) Yes No DK

Do you wear contact lenses? ☐ ☐ ☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐
Date: ____________ If yes, have you had any complications? ____________

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ ☐ ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐
Date Treatment began: ____________

Yes No DK

Do you use controlled substances (drugs)? ☐ ☐ ☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ ☐ ☐
If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ☐ ☐ ☐
If yes, how much alcohol did you drink in the last 24 hours? ____________
If yes, how much do you typically drink i n a week? ____________

WOMEN ONLY Are you:
Pregnant? ☐ ☐ ☐
Number of weeks: ____________
Taking birth control pills or hormonal replacement? ☐ ☐ ☐
Nursing? ☐ ☐ ☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

Allergy	Yes	No	DK
Local anesthetics ____	☐	☐	☐
Aspirin ____	☐	☐	☐
Penicillin or other antibiotics ____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills ____	☐	☐	☐
Sulfa drugs ____	☐	☐	☐
Codeine or other narcotics ____	☐	☐	☐
Metals ____	☐	☐	☐
Latex (rubber) ____	☐	☐	☐
Iodine ____	☐	☐	☐
Hay fever/seasonal ____	☐	☐	☐
Animals ____	☐	☐	☐
Food ____	☐	☐	☐
Other ____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Condition	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Condition	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion (If yes, date: ____)	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders (If yes, specify: ____)	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders (Specify: ____)	☐	☐	☐
Recurrent Infections (Type of infection: ____)	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: Phone: *Include area code* ( )

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

Consent For Dental Treatment **Robert Atwell DDS**

___________ ______________________________ ______________

Date **Patient Name** **Date of Birth**

I request and authorize Dr. Robert Atwell to provide general dental treatments for me.

I further request and authorize the taking of dental x-rays, the use of such anesthetics that may be considered necessary and/or advisable to diagnose and/or treat my/the dental patient's conditions, and provide treatments as deemed necessary and/or advisable by the doctor responsible for my/the dental patient's treatment.

The usual and most frequent risks for complications occurring form dental treatment include, but are not limited to, the possibility of pain or discomfort during and following treatment, swelling, infection, bleeding, sensitivity, injury to adjacent teeth and surrounding tissues, reactions to injections(local anesthesia) such as numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth(which is usually transient but on occasion, may be permanent), and allergic reactions to anesthetics and other dental materials, changes in occlusion(biting), development of a transient or permanent temporomandibular joint (TMJ) problem (including, but not limited to muscle cramps or spasm, referred pain to ear, neck, or head); delayed healing and treatment failure.

The risks of complications from medications used/prescribed include, but are not limited to drowsiness, lack of awareness and coordination, nausea, vomiting, allergic reaction, etc, Some medications may be influenced by the use of alcohol, tranquilizers, sedatives, or other drugs. It is not advisable to operate any motor vehicle or hazardous device while experiencing side effects of any medications we may prescribe. It is important to know that antibiotics decrease the effectiveness of oral contraceptives, so it is advised that other, additional contraceptive measures be taken during the administration of antibiotics.

I understand that during the course of my/the patient's dental treatment something unexpected may arise that may necessitate procedures in addition to or different from those planned. I am aware that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made concerning the results of the treatment that I/the patient will receive.

All of my questions have been answered to my satisfaction.

I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent of treatment and procedures have already been performed or initiated.

Consent Certification

I certify that I have explained the nature, purposed, benefits, the usual and most frequent risks and hazards of, and alternative to, general dental treatment. I have offered to answer any questions and have fully answered such questions. I believe that patient/relative/guardian understands what I have explained and has consented to receive general dental treatment by myself and my associates.

I confirm that I have read this form or it was read to me, and that all inapplicable paragraphs, if any, were crossed out before I signed below.

Patient Signature: __________________________ Date:______________ Print Name: _________________________

If other than the patient, indicate relationship: ________________________

Robert S. Atwell DDS | 715 Hammond St. Bangor, ME 04401 | (p)207.945.6493 (f)207.945.6003 | frontdesk@fairmountdental.me

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO FAIRMOUNT DENTAL

____

____

____

Patient name, address and date of birth

I hereby request and authorize you, your authorized employees and/or agents, permission to send copies, disclose and/or discuss my dental health care information in your possession to Fairmount Dental.

____

____

____

Name of Dental Practice, address, tel. # and email address

My authorization to release includes:

Copies of my medical, social and dental histories, clinical exam and diagnostic records, radiographs, clinical photos, treatment plans, treatment progress records, referral and consultation recommendation and notes, diagnostic and working casts, pharmaceutical, medical and dental lab prescriptions and results, office notes and other related records that would assure continuity of my dental care.

I understand I may request a copy of this authorization. By signing below, I herby release the holder from all liability, and claims pertaining to this transfer of healthcare information. I understand that any refusal to release or revocation of this consent may result in improper diagnosis or treatment. I understand that I may review all information before its release.

Signed: ______________________________**Date** _________ _________________________

Patient **Parent Guardian / Authorized Representative**

Rev. 7/2024

Our Financial Policy

Payment for services rendered is due at the time of service.

Cash, check or credit cards such as Visa, Discover, MasterCard or American Express are accepted. We also accept Care Credit.

Cash payments for services totaling over $500.00 are eligible for a 5% accounting discount. This is only applicable if the bill is paid in full, with a cash or check, the day of service. This courtesy does not apply when we are billing insurance.

IMPORTANT NOTE REGARDING DENTAL INSURANCE

YOU are the guarantor of your account, not your insurance company. Dental insurance is an adjunct to your financial relationship with our practice. We will collect ESTIMATED CO-PAYS at time of service with the exceptions of your INITIAL VISIT, and for exams for patients of other practices, which will be collected in full, and subsequently billed to your insurance.

Often, insurance companies underestimate what your portion will be, or do not pay what was expected based on your plan information. There may be a balance due AFTER insurance pays, in spite of the estimate provided by your insurance company. **PLEASE BE AWARE - YOU WILL RECIEVE A BILL for this balance if the amount paid by your insurance does not cover the total fee for your service(s).**

In the event that insurance pays more than was estimated, a credit will be placed on your account. We can place the credit toward a future visit, or reimburse you via check. Sometimes, the credit must be paid back to your insurance company upon their request.

If your insurance company reimburses **you** directly, we will collect in full at time of service for services rendered.

We file claims to your insurance as a courtesy to you. If a claim is denied, or delayed, the overdue balance is billable to you. At this point, you may contact your insurance company to be reimbursed directly, but we will not file claims for procedures that have been completed over 30 days..

Debt that is unpaid 30 days after the date of service will be considered delinquent. Accounts that are over 90 days late may be referred to a collection agency. THIS POLICY ALSO APPLIES TO INSURANCE CLAIMS. Claims that are unpaid after 90 days will be billed to you. If your insurance pays after 90 days, your initial payment will be credited to your account, or disbursed to you via check.

Failure to comply with this policy will result in dismissal from the practice.

Thank you for your understanding.

“I acknowledge that I am solely responsible for my account with Fairmount Dental and will abide by this policy”

x ________________________________ **DATE:** ___________________

Fairmount Dental
715 Hammond Street
Bangor, Maine 04401
(207)945-6493

MISSED APPOINTMENT POLICY

When we schedule your appointment, a specific amount of time is reserved especially for you. If for any reason you must cancel or change your appointment, it is important that you give our office at least 24 – 48 hours notice so that we may offer that time to someone else.

- First Missed Appointment: If an appointment is missed or cancelled within the 24 – 48 hour window, a letter will be sent reminding you of our policy.
- Any missed appointments following the first: You will be placed on a short call list and will be notified when there is a cancellation or opening in the schedule.
- For New Patients: You will not be reappointed if your appointment is cancelled with less than 24 hours notice or if you do not show for your initial appointment.

We understand that emergencies happen and sometimes prevent us from keeping appointments. If you had an emergency or an issue that caused you to miss an appointment, let us know and the "missed appointment" will be removed from your record.

I have read the above policy, understand it and agree to abide by the terms listed above.

Signature_______________________________________Date________________

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.

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 acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please Specify)

715 Hammond Street, Bangor ME 04401

Phone (207) 945-6493 Fax (207) 947-6003

frontdesk@fairmountdental.me

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
OUR PRIVACY PRACTICES COMPLY WITH OMNIBUS 2013-EFFECTIVE 01/01/2020

Robert Atwell, DDS is 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 the Notice while it is in effect. This Notice takes effect 1/1/2021 and will remain in effect until we replace it.

We reserve the right to change out 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 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

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 entitle to special confidentiality protections under applicable state or federal law. We will abide by these special 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 you care. Payment activities, 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, conduction 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 you 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 our health information to assist in disaster relief efforts.

Public Health Activities. We may disclose our 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.

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 institutional or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services. When required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your protected health (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 purposed 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,

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved bay an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI 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 disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

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 purposes other than those provide for in the Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing our 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 coping, 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 requirement of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting disclosure 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 purposed of carrying out payment or health care operation, 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 our request under certain circumstances. If we agree to your request, we will amend our 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 (email).

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 a 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 of 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.

Our Privacy Officer: Courtney Cray

Telephone: (207) 945-6493 Fax: (207)947-6003

Address: 715 Hammond Street, Bangor, ME 04401

Email: frontdesk@fairmountdental.me