Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Student ☐ Other _____

Social Security #: _____ Birth Date _____ Email: _____

Phone (Home): _____ (Work): _____ Ext _____ Mobile: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

Employer _____ Work Phone _____ Occupation: _____

Address:
Street City State Zip Code

The following is for the patient.

Employer _____ Work Phone _____ Occupation:

Address: _____
Street City State Zip Code

Medical Health Information

Physician _____ Office Phone _____

Person to contact in case of emergency _____ Phone _____

	YES	NO
Are you taking any prescription/non-prescription medications, vitamins or herbs? If **yes** what medication(s) are you taking? _____	☐	☐
Have you ever been told to pre-medicate prior to any dental appointment?	☐	☐
Do you use Alcohol?	☐	☐
Do you use Tobacco?	☐	☐
Do you have a persistent cough or throat clearing **not** associated with a known illness (lasting more than 3 weeks)?	☐	☐

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS or HIV
- ☐ Allergies
  - ☐ Local Anesthetics
  - ☐ Penicillin
  - ☐ Sulfa Drugs
  - ☐ Barbiturates
  - ☐ Sedatives
  - ☐ Iodine
  - ☐ Aspirin
  - ☐ Other _____
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Cancer
- ☐ Chest Pains
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Fen-phen/Redux
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Jaundice
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Cardiac Pacemaker
- ☐ Pregnancy-
  Due date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ STD(s)
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers

OTHER:

- ☐ _____
- ☐ _____
- ☐

Patient Dental History

	YES	NO
Do your gums bleed while brushing or flossing?	☐	☐
Are you sensitive to hot or cold liquids/foods?	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
Do you feel pain in any of your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Have you ever experienced any of the following problems in your jaw?	☐	☐
• Clicking?	☐	☐
• Pain (Ear, Side of Face)?	☐	☐
• Pain in TMJ (Temporomandibular Joint)?	☐	☐
• Difficulty in opening or closing?	☐	☐
• Difficulty in chewing?	☐	☐

	YES	NO
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you ever had any difficult extractions?	☐	☐
Have you had any Orthodontic work?	☐	☐
Have you ever hadprolonged bleeding Following extractions?	☐	☐

Date of Last Dental Visit: _____

What is your chief complaint and reasoning for appointment? _____

_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:

_____

_____

_____

Comments:

_____

_____

_____

_____

Signature of Dentist **Date**

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

Responsible Party Information

The following is for the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐Single ☐Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Mobile: _____ Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Dental Insurance Information

☐ ☐

Primary

Name of Subscriber: _____ Is subscriber a patient? Yes No
Last First MI

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to subscriber☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name_____ Address:_____

Phone Number _____ ID # _____

Secondary *If Applicable

Name of Subscriber: _____ Is subscriber a patient? ☐Yes ☐No
Last First MI

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other_____

Insurance Plan Name: _____ Address: _____

Phone Number: _____Group #: _____ _____

Referral Information

How did you hear about our office? ☐ Another patient/friend, if so what is their name? :_____

☐ Google ☐ Yelp ☐ School ☐ Work ☐ Insurance Company ☐ Driving By ☐ Other _____

The REFERRAL of your friends and family is the GREATEST compliment you can give to us at Kutztown Dental Health!!!

Consent of Services - Office Policy – Office Philosophy

OFFICE PHILOSOPHY

Our office remains dedicated to providing optimal care for every patient and working with you to achieve that goal. We pride ourselves on helping you in any way and continuing to provide the quality of care to which you have become accustomed.

ELECTIVE SERVICES

Some services are typically not covered by dental insurance companies. These include, but are not limited to: Cosmetic dentistry, Chips or cracks in teeth or older restorations, Implants, Occlusion or bite redesign, Posterior composites, and other services.
Although these are important dental services that can greatly enhance the quality of life for patients and may be needed in most cases, Some dental insurance companies do not feel they should have to pay for these services. That is why these services are rarely included in contracts with your employers.

OFFICE POLICY

We have done our best to obtain ESTIMATED dental benefits based on our office fees. You are expected to pay your estimated portion At The Time Services are rendered unless other arrangements have been made in advance.

Please note that our office is a participating provider with several insurance companies, however, we are unable to determine in advance the actual final payment from your dental insurance company until ALL claims close and are finalized. Upon receipt of final payment from the insurance company, in the case of overpayment, your account will be credited. In the event of an underpayment, we will generate a billing statement for the unpaid balance.

I understand that the fee estimate listed for dental care can only be extended for a period of six months from the date of the patient examination.

I grant my permission to you or your assignee to contact me at home or at my work to discuss matters related to this form.

Finally, it is important to remember, services are provided to you and not to your insurance company. You are financially responsible.

I have read the above conditions of treatment and payment and agree to their content.

X _____ **/ /** _____

PATIENT/PARENT, or GUARDIAN SIGNATURE **Date**

Written Financial Policy

Thank you for choosing Kutztown Dental Center. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card.
- NO INTEREST PaymentPlans from CareCredit allow you to pay over time with NO INTEREST (1) with no annual fees or pre-payment penalties

Please Note:

Kutztown Dental Center requires payment of patient portion at the time of treatment. Before lab work can be sent out, 50% of the case fee must be paid. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For patients with dental insurance, We are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. Insurance plans do vary greatly; We will estimate the patient's co-pay to the best of our ability. Any portion not covered by your insurance plan is the account holder's (patient's) responsibility.

KUTZTOWN DENTAL CENTER CHARGES $40 FOR PATIENTS WHO MISS OR CANCEL WITHOUT OUR OFFICE STAFF RECEIVING 48-BUSINESS HOURS NOTICE, and $40 for NSF or cancelled checks.

If you have any questions, please do not hesitate to ask. We are here to help you meet your dental needs and to work together for your dental health.

Patient, Parent or Guardian Signature_____

Patient Name (PleasePrint) _____ **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
Please Print Name
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)

_____

_____

HIPAA Compliance Patient Consent Form:

Our Notice Of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, If so, You will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, But if we do, We shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, You consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, Signed by you. However, Such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law
- The practice has the right to restrict the use of information, but the practice does not have to agree to thoserestrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent

May we phone, email or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your dental conditions with any member of your family? YES NO

If YES, please name the family members allowed:

_____

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ **Date:**_____

Witness: _____ **Date:**_____