Patient Information Form

Patient Information:		
Last Name:	First Name:	Middle Initial:
DOB:	Age:	Social Security Number:
Address:		
City:	State:	Zip Code:
Wireless Phone:		
Home Phone:		
E-mail:		

Primary Insurance:	Secondary Insurance:
Insurance Carrier:	Insurance Carrier:
Employer:	Employer:
Group Number:	Group Number:
Subscriber Name:	Subscriber Name:
Subscriber SSN:	Subscriber SSN:
Member ID:	Member ID:
DOB:	DOB:

Emergency Contact Information:
Name of Contact:
Phone Number:
Relationship to Patient:
May we communicate information with this individual concerning your care? ☐ Yes ☐ No

Authorization:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any of my health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts. By signing this statement, I am agreeing to responsibility of services not paid in full or part by my dental care payer.

I attest to the accuracy of the information on this page.

Patient or Guardian Signature Date

Dental History:

Reason for today's visit: | Date of last Dental visit:

Former Dentist: | Date of last Dental X-rays:

Please indicate if you current have or have had any of the following. Checking the box indicates "Yes", leaving blank indicates "No".

- ☐ Bad Breath
- ☐ Blisters on Lips or Mouth
- ☐ Burning Sensation on Tongue
- ☐ Chew on One Side of Mouth
- ☐ Cigarette, Pipe, or Cigar Smoking
- ☐ Smokeless Tobacco
- ☐ Dry Mouth
- ☐ Food Collection Between Teeth
- ☐ Clench or Grind Teeth
- ☐ Growths or Sore Spots in Your Mouth
- ☐ Gums Swollen, Tender or Bleeding
- ☐ Head, Neck, Jaw Pain, or Aches
- ☐ Lip or Cheek Biting
- ☐ Loose Teeth or Broken Fillings
- ☐ Mouth Breathing
- ☐ Orthodontic Treatment
- ☐ Nitrous Oxide
- ☐ Periodontal Treatment
- ☐ Sensitivity to Pressure, Cold, Heat or Sweets

Do you have to take pre-medication prior to receiving dental treatment? ☐ Yes ☐ No
If Yes, please explain:

Have you ever had an allergic reaction to Novocaine, local or general anesthetics? ☐ Yes ☐ No
If Yes, please explain:

Have you ever had trouble from previous dental care? ☐ Yes ☐ No
If Yes, please explain:

Medical History:

Physician's Name: | Physician's Address:

Date and reason for last visit:

Please indicate if you current have or have had any of the following. Checking the box indicates "Yes", leaving blank indicates "No".

Allergies
- ☐ Aspirin
- ☐ Latex
- ☐ Penicillin
- ☐ Other Allergies (List Below)

Conditions
- ☐ Abnormal Bleeding
- ☐ Alcohol Use/Consumption
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma:
  Required Hospitalization ☐
  Have you used steroids? ☐
  Date of Last Episode
  _____
- ☐ Bisphosphonates (Fosomax, Actonel, Boniva, Reclast, Didronel, Zometa)
- ☐ Blood disease, Clotting Disorder
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Contact Lenses
- ☐ Cortisone Treatments
- ☐ Cough, Persistent or Bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Any Immune Deficiency
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Pacemaker
- ☐ Pregnant/Nursing:
  Due Date _____
- ☐ Radiation Treatments
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sinusitis
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Sickle Cell Anemia
- ☐ Skin Rash
- ☐ Slow Healing Wounds
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or Growth on Head and/or Neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss, Unexplained
- ☐ Other Conditions (Explain Below)

OTHER ALLERGIES: List all additional allergies you have below.

_____ _____
_____ _____
_____ _____

OTHER CONDITIONS: Explain all additional conditions you have below.

_____
_____
_____

MEDICATIONS: List any medications you are taking below.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Authorization and Release:

I have read and answered the above questions to the best of my knowledge.

_____
Patient/Guardian Signature **Date**

_____
Doctor Signature **Date**

Financial Agreement:

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- All Patients must complete our "Patient Information Form" prior to being seen by the Dental Professional
- Full Payment is due at the time of Service
- We accept CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT
- This Practice provides insurance company billing as a courtesy to our patients. The patient portion of a particular dental service(s) is estimated and due at the time of service.

Adult Patients

- Adult patients are responsible for payment in full at the time of service.

Minors Accompanied by an Adult

- The adult accompanying a minor, his/her parent, or guardians are responsible for payment in full at the time of service

Unaccompanied Minors

- The parents or guardians are responsible for payment in full at time of service. Non – emergency treatment will be denied unless charges have been pre-authorized. Providers may choose to avoid treating a minor without an adult present at his or her own discretion.

Insurance

- This Practice provides insurance company billing as a courtesy to our patients. The patient portion of a particular dental service(s) is estimated and due at the time of the service. This amount maybe subject to adjustment, when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services which can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of the dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by the staff regarding his/her remaining benefit in any such benefit period. The claims we submit to insurance companies indicate that you have assigned those benefits to. However, if you are paid by the insurance company instead of, you then become responsible for the total account balance and payment would be expected immediately.
- If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available
- You, as a patient, are always responsible for any charges that are not covered by your insurance.

NSF Fee

- All payment returned due to non-sufficient funds will be subject to a NSF fee of $25.00

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

_____ _____

Patient or Guardian Signature Date

Notice of information and Privacy Practices
HIPAA Communication Form

Patient Name: _____ DOB: _____

I have been given a copy of Professional Dental Alliance practice ("Practice**"), *Notice of Information and Privacy Practices* ("**Notice**"), which describes how my health information is used and shared. I understand that the Practice has the right to change this Notice at any time. I may obtain a current copy by contacting the Privacy Officer at (765) 698-2500, or by visiting the Practice's web site.**

Patient privacy is important to us. Our policy to keep patient health information confidential and not disclose such information without your consent or written authorization unless otherwise required by federal or state privacy laws.

Please provide us with information with whom we can communicate with concerning your care. We would also like to obtain information regarding alternative communication preferences so that we know the best way to contact you with appointment reminders or other information related to your care.

Please note: If you have someone accompany you in the treatment area, we will assume this person is entitled to receive information regarding your care and we can freely discuss your health information.

You are free to make changes to your preferences at any time. Updates must be made in person and a new form completed.

Please provide the names and relationship to patient for those individuals you will need or want your health information to be provided. This includes family members, friends, organizations or caregivers/babysitters:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Patient Communication – Our practice is to protect the privacy of our patients while ensuring our patients are kept well informed of their appointments and other information. As a service to our patients, we will communicate appointment reminders and other information via text message, email or via phone. Limited information will be left when leaving a voice massage. Medical information will not be shared when leaving a voice message. Please inform our team if you would prefer we use an additional communication preference for appointment reminders or other information related to your care.

My signature below acknowledges that I have been offered and/or provided with a copy of the Notice of Information and Privacy Practices:

_____

Patient, Guardian, or Personal Representative Signature **Date**

_____

Print Name and/or Personal Representative's Title (e.g., *Guardian, Executor of Estate, Health Care Power of Attorney)*

Patients, please keep this page for your records

Non – Discrimination Policy

Professional Dental Alliance and its affiliates comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Professional Dental Alliance and affiliates do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

If requested, Professional Dental Alliance and affiliates provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

If you need these services, contact the Office Manager at the practice location.
If you believe that Professional Dental Alliance and affiliates have failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with:

Kiena P Nutter- Compliance Coordinator
11 S Mill St
New Castle, PA 16101
724.698.2905
nutterk@nadentalgroup.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kiena P Nutter, Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

V.1 April 19, 2017

Patients, please keep this page for your records

ADA Dental Patient Rights and Responsibilities Statement

Your dentist is the best source of information about your dental health and wants you to feel comfortable about your dental care. Maintaining healthy teeth and gums means more than just brushing and flossing every day and visiting your dentist regularly. As an informed dental patient, it also means knowing what you can expect from your dentist and dental care team and understanding your role and responsibilities in support of their efforts to provide you with quality oral health care.

The rights and responsibilities listed below do not establish legal entitlements or new standards of care, but are simply intended to guide you through the development of a successful and collaborative dentist-patient relationship.

Patient Rights

1. *You have a right to* choose your own dentist and schedule an appointment in a timely manner.
2. *You have a right to* know the education and training of your dentist and the dental care team.
3. *You have a right to* arrange to see the dentist every time you receive dental treatment, subject to any state law exceptions.
4. *You have a right to* adequate time to ask questions and receive answers regarding your dental condition and treatment plan for your care.
5. *You have the right* to know what the dental team feels is the optimal treatment plan as well as the right to ask for alternative treatment options.
6. *You have a right to* an explanation of the purpose, probable (*short and long term*) results, alternatives and risks involved before consenting to a proposed treatment plan.
7. *You have a right* to be informed of continuing heath care needs.
8. *You have a right to* know in advance the expected cost of treatment.
9. *You have a right to* accept, defer or decline any part of your treatment recommendations.
10. *You have a right to* reasonable arrangements for dental care and emergency treatment.
11. *You have a right to* receive considerate, respectful and confidential treatment by your dentist and dental team.
12. *You have a right to* expect the dental team members to use appropriate infection and sterilization controls.
13. *You have a right to* inquire about the availability of processes to mediate disputes about your treatment.
14. You have the right to receive access to treatment and accommodations that are available regardless of race, sex, age, creed, sexual orientation, national origin, religion, handicap, or marital status

Patient Responsibilities

1. *You have the responsibility to* provide, to the best of your ability, accurate, honest and complete information about your medical history and current health status.
2. *You have the responsibility* to report changes in your medical status and provide feedback about your needs and expectations.
3. *You have the responsibility to* participate in your health care decisions and ask questions if you are uncertain about your dental treatment or plan.
4. *You have the responsibility to* inquire about your treatment options and acknowledge the benefits and limitations of any treatment that you choose.
5. *You have the responsibility for* consequences resulting from declining treatment or from not following the agreed upon treatment plan.
6. *You have the responsibility to* keep your scheduled appointments.
7. *You have the responsibility to* be available for treatment upon reasonable notice.
8. *You have the responsibility to* adhere to regular home oral health care recommendations.
9. *You have the responsibility to* assure that your financial obligations for health

Areas within the practice may be limited to some requests for accommodations specifically where facility must maintain a sterile environment.