Patient Information

Patient Name: _____ Preferred Name: _____

Mailing Address:

_____City: _____

State: _____ Zip: _____

Cell #: _____ Home #: _____ DOB: _____ Gender: _____

Email: _____

Check appropriate response: Minor ____ Single ____ Married ____

Emergency Contact

Name: _____ Phone: _____ Relation: _____

Responsible Party (for patients who are under the age of 18)

Name: _____ DOB: _____ Relationship to Patient: _____

Cell #: _____ Home #: _____ Email: _____

Dental Insurance

Insurance Company: _____ Name of Insured: _____

DOB: _____ Relationship to Patient: _____ Employer: _____

Social Security # _____ Policy I.D # _____

If you have secondary insurance, please fill out the information below:

Insurance Company: _____ Name of Insured: _____

DOB: _____ Relationship to Patient: _____ Employer: _____

Social Security # _____ Policy I.D # _____

Signature: _____ Date: _____

PREMIERE DENTAL

Medical History Form

Patient Name: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

1.) Are you under a physician's care now? YES/NO
2.) Have you ever been hospitalized or had a major operation? YES/NO
3.) Have you had a serious head or neck injury? YES/NO
4.) Do you take or have taken, Phen-Fen or Redux? YES/NO
5.) Have you ever taken Fosamax, Bonica, Actonel or any other medications containing bisphosphonates? YES/NO
6.) Are you taking any blood thinners (E.g. Eliquis, Xarelto, Coumadin, Warfarin) YES/NO
7.) Are you on a special diet? YES/NO
7.) Do you use tobacco? YES/NO
8.) Do you use controlled substances? YES/NO
9.) Are you taking any medications, pills, or drugs? YES/NO

If yes, please explain: _____

Women: Are you…

- Pregnant/Trying to get pregnant? YES/NO
- Nursing? YES/NO
- Taking Oral contraceptives? YES/NO

Are you allergic to any of the following? Check here only if NO for all. ☐

- Aspirin Y / N
- Codeine Y / N
- Metal Y / N
- Sulfa drugs Y / N
- Penicillin Y / N
- Acrylic Y / N
- Latex Y / N
- Local Anaesthetics Y / N
- Other Y / N
- _____

PREMIERE DENTAL

Do you have, or have had any of the following? Mark the appropriate response

MARK THIS BOX IF THE ANSWER IS NO TO ALL ☐

☐ AIDS/HIV Positive	☐ Arthritis/Gout	☐ Blood Transfusion	☐ Chest Pains
☐ Cortisone Medicine	☐ Epilepsy/Seizure	☐ Frequent Diarrhea	☐ Heart Attack/Failure
☐ Hemophilia	☐ High Cholesterol	☐ Leukemia	☐ Osteoporosis
☐ Radiation Treatment	☐ Scarlet Fever	☐ Stomach/Intestinal Disease	☐ Tuberculosis
☐ Alzheimer's Disease	☐ Artificial Heart Valve	☐ Breathing Problems	☐ Cold Sores/Fever Blisters
☐ Diabetes	☐ Excessive Bleeding	☐ Frequent Headaches	☐ Heart Murmur
☐ Hepatitis A	☐ Hives or Rash	☐ Liver Disease	☐ Pain in Jaw Joints
☐ Recent Weight Loss	☐ Shingles	☐ Stroke	☐ Tumors or Growths
☐ Anaphylaxis	☐ Artificial Joint	☐ Bruise Easily	☐ Congenital Heart Disorder
☐ Drug Addiction	☐ Excessive Thirst	☐ Genital Herpes	☐ Heart Pacemaker
☐ Hepatitis B or C	☐ Hypoglycemia	☐ Low Blood Pressure	☐ Parathyroid Disease
☐ Renal Dialysis	☐ Sickle Cell Disease	☐ Swelling of Limbs	☐ Ulcers
☐ Anemia	☐ Asthma	☐ Cancer	☐ Convulsions
☐ Easily Winded	☐ Fainting Spells/Dizziness	☐ Glaucoma	☐ Heart Trouble/Disease
☐ Herpes	☐ Irregular Heartbeat	☐ Lung Disease	☐ Psychiatric Care
☐ Rheumatic Fever	☐ Sinus Trouble	☐ Thyroid Disease	☐ Venereal Disease
☐ Angina	☐ Blood Disease	☐ Chemotherapy	☐ Yellow Jaundice
☐ Emphysema	☐ Frequent Cough	☐ Hay Fever	☐ High Blood Pressure
☐ Kidney Problems	☐ Mitral Valve Prolapse	☐ Rheumatism	☐ Spina Bifida
☐ Tonsilitis			

Have you ever had any serious illness not listed above? _____

Signature: _____ Date: _____

PREMIERE DENTAL

Consent For Treatment

- I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnosis aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) dental needs.
- Upon such a diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such as assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complication.
- Premises are under 24-hour audio and video surveillance.
- I give consent to the doctors or designated staffs use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations, I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
- I agree to be responsible for payment of all services rendered on my behalf or my dependent. I understand that payment is due at the time of service unless other arrangements have been made.
- If for any reason my account is sent to collections, a 50% collection fee will be added to my balance and turned over to a collection agency.

FINANCIAL POLICY

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand payment is due at the time of service. I understand any treatment fee will be honored up to 90 days from the date of examination. I understand, in order to collect any debt, my credit history may be checked through the use of my social security number and any other information given.

I agree that in the event my account becomes delinquent due to non-payment and is turned over to an outside collection attorney or agent, I agree to pay all actual and reasonable fees, legal fees, costs, expenses, and court costs incurred in the collection.

Payment is due at the time services are rendered. For your convenience, we accept Visa, MasterCard, American Express, Discover, CareCredit, LendingPoint, Sunbit, among other credit providers. We apply a surcharge of 3.5% to payments made using a credit card, which is in line with our cost of acceptance. Any deductible or estimated co-payment amount will be due at the time of treatment.

I grant my permission to this office to phone or email me to discuss my account, appointments, or treatment.

As a courtesy to me, I understand this office will file any dental insurance for me. I hereby authorize release of any information needed and also authorize my insurance company to pay directly to this office benefits accruing under my policy. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

I understand this office will always do the best to help me maximize my dental benefits; however, ultimate responsibility for payment is mine and I am obligated and agree to pay this office in accordance with its credit terms and policy.

Patient/Legal Guardian Signature: _____ Date:_____

PREMIERE DENTAL

Appointment Cancellation Policy

At Premiere Dental, we are committed to providing exceptional dental care to all our patients. To maintain this standard of service, we have UPDATED our Appointment Cancellation Policy designed to facilitate efficient scheduling for everyone.

When you schedule an appointment, that time is reserved exclusively for you. **If you are unable to attend, we kindly ask that you notify our office at least 48 hours in advance.** This notice allows us to offer the appointment slot to another patient in need of care.

**Our Policy is as Follows: **

48 Hours' Notice: We require a minimum of 48 hours' notice for any appointment rescheduling or cancellation.
Missed Appointments: If you fail to provide the required notice, your appointment will be classified as a missed appointment.
Cancellation Fee: A fee of $75 will be applied for missed appointments. Please note that this fee is not billable to your insurance and will be your direct responsibility.
Future Appointments: No future appointments can be scheduled, nor can patient records be transferred, until the cancellation fee has been paid.

We appreciate your understanding and cooperation in this matter, as it helps us serve all our patients more effectively. Thank you for choosing Premiere Dental for your dental care needs.

_____
Signature

_____
Date

HIPAA Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of Premiere Dental of Abington. "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

•Maintain the privacy of your protected health information;

•Give you this Notice of our legal duties and privacy practices with respect to that information; and

•Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on April 21, 2020.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text, or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, contact Premiere Dental of Abington.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you upon request. The effective date of this Notice is 04/21/2020.

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

Patient Name: _____ Signature: _____ Date: _____