Providence Dental Associates
350 S. Providence Rd.
Media, PA 19063

New Patient Information and Forms

Please review, print, and sign the enclosed documents in advance of your first appointment. Our office staff will be happy to address any questions you may have. We look forward to seeing you!

1. Dental and Medical History
2. Health Questionnaire Acknowledgement
3. Office Financial Policy
4. Disappointment Policy
5. Authorization for Signature on File
6. Acknowledgement of Notice of Privacy Practices
7. Notice of Privacy Practice

PATIENT INFORMATION

DATE ____________________

NAME ______________________________ ☐MARRIED ☐SINGLE ☐MINOR ☐MALE ☐FEMALE
LAST FIRST M

SOCIAL SECURITY # ______________________________

ADDRESS ______________________________
STREET APT. # CITY STATE ZIP

BIRTHDATE ____________________ TELEPHONE ______________________________
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER ______________________________ ADDRESS ____________________

IF FULL TIME STUDENT, SCHOOL NAME ______________________________ GRADE __________

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐PATIENT ☐GUARDIAN ☐SPOUSE ☐FATHER ☐MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY	**SECONDARY INSURED**
LAST FIRST M	LAST FIRST M
STREET CITY STATE ZIP	STREET CITY STATE ZIP
HOME WORK CELL E-MAIL	HOME WORK CELL E-MAIL
BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT	BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT
EMPLOYER DENTAL INS. CO	EMPLOYER DENTAL INS. CO
SS# SUBSCRIBER # GROUP #	SS# SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Name ______________________________

Address ______________________________

City/State/ZIP ______________________________

Telephone # ______________________________

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X ______________________________
Patient or Responsible Party

____
Date State Driver's License #

Has any member of your family ever been treated in our office?
☐Yes ☐No

Whom may we thank for referring you to our office?

____

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐Yes ☐No

☐Payment in full at each appointment (cash or personal check)

☐Payment in full at each appointment (☐VISA ☐MC ☐OTHER)

Card # ____________________ Exp. Date __________

☐I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of ______% per month (or a minimum charge of $_______ for a balance under $_________) which is an annual percentage rate of _______% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

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PATIENT NAME ______________________________ **DATE** ______________

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Please Circle

Question		
Do you have a specific dental problem? Describe ________	Yes	No
Do you have dental examinations on a routine basis? Last visit ________	Yes	No
Do you think you have active decay or gum disease? ________	Yes	No
Do you brush and floss on a routine basis? Discuss ________	Yes	No
Do your gums ever bleed? Discuss ________	Yes	No
Do you like your smile? Why? ________	Yes	No
Does food catch between your teeth? Any loose teeth? ________	Yes	No
Do you want to keep your remaining teeth? ________	Yes	No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? ________	Yes	No
Have your past experiences in a dental office always been positive? ________	Yes	No
Do you smoke or chew? Any sores or growths in your mouth? Discuss ________	Yes	No

Name of previous dentist (optional): ________

Date of last full mouth x-rays (16 small films or panoramic): ________

Medical History

Question		
Are you under a physician's care now? Why? ________ Who? ________ Phone ________	Yes	No
Have you ever been hospitalized or had a major operation? Discuss ________	Yes	No
Have you ever had a serious injury to your head or neck? Discuss ________	Yes	No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? ________	Yes	No
Are you on a special diet? Discuss ________	Yes	No
Are you allergic to any medications or substances? Please check box below ________	Yes	No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Milk ☐ Other ________

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss ________ Yes No

Do you now have or have you ever had any of the following? Please check appropriate boxes.

*If yes to any of the starred conditions, please call prior to your appointment... premedication or changes in medication may be required.

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Heart Disease/Surgery*	☐	☐	Excessive Bleeding	☐	☐	Chemotherapy	☐	☐	Night Sweats	☐	☐	Cold Sores	☐	☐
Heart Murmur or Defect *	☐	☐	Sickle Cell Disease	☐	☐	Osteoporosis	☐	☐	Yellow Jaundice	☐	☐	Fever Blisters	☐	☐
Irregular Heart Beat	☐	☐	Hemophilia (Bleeding Problem)	☐	☐	Bisphosphonates	☐	☐	Kidney Problems	☐	☐	Herpes	☐	☐
Angina/Chest Pain	☐	☐	Leukemia	☐	☐	Osteonecrosis of Jaw	☐	☐	Renal Dialysis	☐	☐	Stroke	☐	☐
Heart Attack/Failure	☐	☐	Recent Blood Transfusion	☐	☐	Aredia I.V.	☐	☐	Thyroid Disease	☐	☐	Convulsions	☐	☐
Congenital Heart Disorder*	☐	☐	Swelling of Limbs	☐	☐	Zometa I.V.	☐	☐	Parathyroid Disease	☐	☐	Epilepsy or Seizures	☐	☐
Mitral Valve Prolapse *	☐	☐	Lung Disease	☐	☐	Fosamax, Actonel, Boniva	☐	☐	Arthritis/Gout	☐	☐	Fainting or Dizziness	☐	☐
Scarlet Fever	☐	☐	Breathing Problem	☐	☐	Stomach/Intestinal Disease	☐	☐	Rheumatism	☐	☐	Glaucoma	☐	☐
Rheumatic Fever *	☐	☐	Shortness of Breath	☐	☐	Ulcers	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Artificial Heart Valve *	☐	☐	Frequent Cough	☐	☐	Recent Weight Loss	☐	☐	Cortisone Medicine	☐	☐	Nervousness	☐	☐
Heart Pace Maker*	☐	☐	Hay Fever	☐	☐	Frequent Diarrhea	☐	☐	Artificial Joint *	☐	☐	Psychiatric Care	☐	☐
Pulmonary Shunt*	☐	☐	Sinus Trouble	☐	☐	Diabetes	☐	☐	Venereal Disease	☐	☐	Alzheimer's Disease	☐	☐
High Blood Pressure	☐	☐	Asthma	☐	☐	Excessive Thirst	☐	☐	AIDS	☐	☐	Allergies (Medicines)	☐	☐
Low Blood Pressure	☐	☐	Bloody Sputum	☐	☐	Hypoglycemia	☐	☐	HIV Positive	☐	☐	Allergies (Pollen / Dust)	☐	☐
Bacterial Endocarditis*	☐	☐	Emphysema	☐	☐	Liver Disease	☐	☐	Genital Herpes	☐	☐	Hives or Rash	☐	☐
Unexplained Fever	☐	☐	Tuberculosis	☐	☐	Hepatitis A (Infectious)	☐	☐	Drug Addiction/Alcoholism	☐	☐	Need Premedication?	☐	☐
Bruise Easily/Blood Disease	☐	☐	Cancer	☐	☐	Hepatitis B or C	☐	☐	Tattoos/Body Piercing	☐	☐	Ever taken fen-phen?*	☐	☐
Anemia	☐	☐	X-Ray Treatments (Radiation)	☐	☐							Cochlear implants?	☐	☐
Coronary Stent*	☐	☐												

Have you ever had any other serious illness not checked above? Discuss ________ Yes No

Do you wish to talk to the dentist privately about any problem? ________ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X ______________________________ Date ________

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor ________ Date ________ BP ________ Pulse ________

History Review and Significant Findings ________

Medical Updates

I have read my MEDICAL HISTORY dated ________ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.

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DENTAL AND MEDICAL HISTORIES - UPDATES

Providence Dental Associates
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Health Questionnaire Acknowledgment and Consent to Proceed

Name____

Address________________________________City__________________________State_____

Zip____________ Telephone___________________

Social Security # ________________________

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify my dental provider of any changes at any subsequent appointment.

I authorize Dr. _____________________________ and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic, or surgical treatments.

I do voluntarily assume any and all possible risks, including the rist of substantial an serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I understand that placement of restorations may render the involved teeth sensitive to hot and cold temperatures and/or pressure for an extended period of time.

I also consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

____
Signature of Patient, Legal Guardian, or Authorized Agent of Patient

______________________________ ____________________
Relation to Patient Date

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Office Financial Policy

Thank you for choosing our office as your dental provider. We are committed to your treatment being successful and to our relationship being professional and long lasting. Please understand that we will work with you and your insurance provider to insure maximum benefits and speedy settlement. The following is a statement of our financial policy, which we request you read and sign prior to treatment.

Out-of-Network Insurance Plans and Your Responsibility

We ask that the fee paid at the time when service are rendered unless other arrangements are made with the doctor prior to treatment. We will submit the necessary paperwork via the mail or electronically to your insurance and have benefits sent directly to you. **It is the policy of this office that you leave up to 50% of the total fee for major procedures unless you have been otherwise instructed.** Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your out-of-network insurance company has not paid your account within 60 days, you will be responsible for payment of the balance. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under dental insurance. If and when your insurance does make payment and you are entitled to a refund, Providence Dental Associates or a representative of Providence Dental Associates will issue a refund check within 7 days of the receipt of that insurance payment.

Cancelled and Missed Appointments

Please refer to the Disappointment Policy of this office.

Returned Checks

Checks returned by your bank are subject to a $30 processing fee. Accounts past due over 30 days are subject to a 1.5% service charge per month (18% per Annum). Minimum service charge is $2 per month.

Collections

If your account is referred for collection, you will be responsible for collection costs, up to the amount of 50% of the outstanding balance, together with court costs and reasonable attorney's fee.

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

I have read the Financial Policy and I understand and agree with the Financial Policy.

______________________________________ _______________
Signature of Patient, Parent, or Guardian Date

____
Relationship to Patient

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Disappointment Policy

Why a disappointment policy?
Here at Providence Dental Associates, we schedule appointments ahead of time so as to provide you with the best care possible. When patients do not keep a scheduled appointment, the time that was set aside is wasted and another patient that could have used that time does not get to be seen.

What is the disappointment policy?
The Providence Dental Associates disappointment policy is as follows:
"If a patient fails to keep an appointment, fails to give at least 24 hours notice of a cancellation, or is at least 20 minutes late, the patient is considered to have 'disappointed'."

What is considered a disappointment?
1. Not showing up for your scheduled appointment.
2. Not calling to cancel your scheduled appointment with at least 24 hours notice.
3. Arriving 20 or more minutes late for your scheduled appointment.

What will happen if I disappoint a scheduled appointment?
1. Upon your **first disappointment**, you will receive a letter informing you that you have disappointed and that your disappointment was documented in your permanent record.
2. Upon your **second disappointment**, you will receive a letter informing you of your second disappointment and you will be assessed a **$100** fee.
3. Upon your **third disappointment**, you will be assessed an additional **$100** fee.

If there are any further disappointments, we reserve the right to request that you seek treatment elsewhere. If you are assessed a disappointment fee, and fail to pay this fee, we reserve the right to suspend treatment and limit treatment to emergency treatment only until such fees are paid in full.

How do I cancel an appointment?
We understand circumstances and emergencies do arise and that sometimes exception must be made. However, we ask that you make every effort possible to cancel your appointment with at least 24 hours notice; or give us a call if you are behind schedule. The office can be reached at (610) 566-3326. We ask that you call during business hours and do not leave notices on the answering machine.

Although the office schedule tends to be very busy, if you call the office in the morning on a day which you are certain you can come in, we maybe able to accommodate you thereby preventing time loss on our part.

Thank you for your understanding in this matter. Through your co-operation, we will be able to provide you with the best possible care.

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Authorization for Signature on File

Release of Information/Financial Responsibility/Authorization for payment

I,______________________________________and/or___________________________________
Name of Patient (Parent or Guardian if minor) Name of Insured

Hereby authorize Providence Dental Associates to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with:

____

I hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed above. To the extent permitted under applicable law, I authorize release of any information relating to the claim.

_____________________________________ _______________________________________
Signature of Insured Witnessed by

_______________________________________ __________________
Signature of Patient (Parent or Guardian if Minor) Date

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

*** You May Refuse to Sigh This Acknowledgement ***

I ____ have received and/or reviewed a copy of Providence Dental Associate's **Notice of Privacy Practice**

____
Please Print Name

____ ___________
Signature Date

For Office Use

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign.
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us form obtaining acknowledgement
- o Other (please specify)

____

____

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NOTICE OF PRIVACY PRACTICE

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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our Privacy Practices, our legal duties, and your rights concerning your health information. We must follow the Privacy Practices that are described in this Notice while it is in effect. This Notice takes effect **4-13-03** and will remain in effect until we replace it.

We reserve the right to change our Privacy Practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our Privacy Practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our Privacy Practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional

judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you **$0.65** for each page, **$16.00** per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us by using the information listed at the end of this Notice for a full explanation of our fee structure).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposed, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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 your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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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 you disagree with a decision we made about 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 and 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.