# Patient Information Form

| | | | | |
|---|---|---|---|---|
| Name: Last | First | Middle | DOB: | Age: |
| Preferred Name/Nickname: | | Social Security Number: | | Sex: |
| Address: | City: | State: | Zip Code: | |
| Email Address: | Wireless Phone: | Home Phone: | | Work Phone: |

| Primary Insurance: | Secondary Insurance: |
|---|---|
| Insurance Carrier: | Insurance Carrier: |
| Insurance Carrier Phone: | Insurance Carrier Phone: |
| Employer: | Employer: |
| Group Number: | Group Number: |
| Subscriber Name: | Subscriber Name: |
| Subscriber SSN: | Subscriber SSN: |
| Member ID: | Member ID: |
| DOB: | DOB: |
| Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child | Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child |

## Emergency Contact Information:

Name of Contact: Phone Number: Relationship to Patient:

May we communicate information with this individual concerning your care? ☐ Yes ☐ No

## Dental Information:

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

Former Dentist: Date of last Dental X-rays:

***Please indicate if you currently 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
- ☐ Clench or Grind Teeth
- ☐ Dry Mouth
- ☐ Food Collection Between 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
- ☐ Smokeless Tobacco
- ☐ Cigarette, Pipe, or Cigar Smoking

If yes, Frequency: _____ Quantity: _____

**Premedication** ☐ **Yes** ☐ **No**

Do you have to take pre-medication prior to receiving dental treatment?

If Yes, please explain:

**Anesthetic Allergy** ☐ **Yes** ☐ **No**

Have you ever had an allergic reaction to Novocaine, local or general anesthetics?

If Yes, please explain:

Have you ever had trouble from previous dental care? ☐ Yes ☐ No

If Yes, please explain:

## 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

# Patient Health History

| | |
|---|---|
| **Physician's Name:** | Date and reason for last visit: |
| **Physician's Phone:** | |
| Address/City/State/Zip: | List and date any serious injuries, illnesses, operations or hospitalizations below. |

***Please indicate if you currently 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
  _____
- ☐ Autoimmune disease
- ☐ Blood Transfusion
- ☐ Blood Clotting Disorder
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chemical/Drug Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Contact Lenses
- ☐ Cortisone Treatments
- ☐ Cough, Persistent or Bloody
- ☐ Diabetes: HbA1C _____
  Date Taken _____
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis: Type _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hormone Imbalance
- ☐ Immune Deficiency
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Health Disorders
  Specify: _____
- ☐ Mitral Valve Prolapse
- ☐ Neurological Disorders
  Specify: _____
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Pacemaker
- ☐ Persistent Cough
- ☐ Pregnant / Nursing
  Number of weeks: _____
  Due Date: _____
- ☐ Radiation Treatments
- ☐ Rheumatic Fever
- ☐ Respiratory Disease
- ☐ Sexually Transmitted Disease
- ☐ 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**: List any additional conditions or information below.

**Medications:** List any medications you are taking below.

| | |
|---|---|
| **Pharmacy Name:**<br>**Pharmacy Number:** | Address/City/State/Zip: |
| **Joint Replacement** ☐ Yes ☐ No<br>Have you had an orthopedic total joint (hip knee, elbow, finger) replacement?<br>If yes, have you had any complications?<br>_____ | **Bisphosphonates** ☐ Yes ☐ No<br>Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Boniva, Reclast, Prolia, Didronel, Zometa) for osteoporosis or Paget's Disease? |
| Do you use controlled substances (drugs)? ☐ Yes ☐ No<br>If so, please specify what how often below: | Do you drink alcoholic beverages? ☐ Yes ☐ No<br>If yes, how much alcohol did you drink in the last 24 hours? _____<br>If yes, how much do you typically drink in a week? _____ |

**Authorization and Release**: I have read and answered the above questions to the best of my knowledge.

☒ _____
Patient or Guardian Signature Date

☒ _____
Doctor Signature Date

# Consent for Treatment of a Minor Child without a Parent/Guardian present

Patient Name: _____ DOB:_____

**All minors seeking dental treatment must be accompanied by a parent/legal guardian during the initial office visit.** After the initial appointment, a minor may be seen for treatment only with written authorization from the parent/guardian under the conditions specified in this consent. To allow for treatment of patients who are considered minors, it is necessary for a parent or legal guardian to give consent for treatment. If a minor child presents for a nonurgent appointment without a parent or legal guardian or a signed consent, treatment may be denied. If the parent/legal guardian cannot attend the appointment, the following instructions that you select will be adhered to in the treatment of the minor patient (check all that apply):

- ☐ **ROUTINE DENTAL CARE:** The consent for the dental practice to complete routine dental care such as x-rays, prophylaxis (cleaning), fluoride and/or other treatment previously discussed.
- ☐ **SIGN FORMS AND CONSENTS:** The consent to sign any and all forms and consent required to give permission to North American Dental Group and its associates to treat the dental needs of my child**.**
- ☐ **DISCUSS FINANCES:** The consent to the dental practice to discuss finances (treatment charges, account balances, next visit charges) with my child and/or the appointed adult indicated below.
- ☐ **DISCLOSE TREATMENT NEEDS**: The consent to the dental practice to discuss my child's future dental treatment needs (ie. treatment plans) with my child and/or the appointed adult indicated below. I understand this does not obligate me to the treatment, only that the office has informed me or my representative of the dental needs of my child.
- ☐ **SCHEDULING:** The consent to schedule future dental visits for my child.

**If you need to send your child to their appointment with an adult other than yourself/legal guardian, please complete this section. The person(s) listed below will have consent to all of the items checked above.**

*All minor patients MUST be accompanied with an adult/caregiver for ANY appointment that requires numbing and/or anesthetics.*

I appoint the following adult(s):

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

to consent to dental treatment which is deemed necessary by North American Dental Group and its associates as authorized herein. I authorize the following adult /caregiver to consent to any necessary examination, anesthetic, imaging, diagnosis, and or treatment rendered for the minor names above under the general or special supervision and on the advice of any licensed provider. I accept financial responsibility for any services provided for my child in my absence.

*** I understand I am responsible for all charges or fees incurred and co-payments must be made at the time of service as our financial policy states. We will gladly process payments over the phone if a credit card is used.**

**LIMITATIONS:** Identify any specific limitations on the kinds of dental services/treatment for which this authorization is given. If none, please state "NONE".

_____

I, _____, am the parent/legal guardian of the minor child _____. I have the legal right to consent for medical treatment for this patient. I hereby authorize North American Dental Group and its Associates to provide dental treatment as indicated above. **I understand this consent will be valid for one year or until I rescind this agreement in writing.**

_____

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

## Privacy Policy

*Notice of information and Privacy Practices*
*HIPAA Communication Form*

**Patient Name:**

**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 (724) 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 you or your child's health information and care. This includes family members, friends, organizations or caregivers and babysitters.

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

***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.***

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

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

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**Patient or Guardian Signature** **Date**

☒

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

## 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 us. However, if you are paid by the insurance company instead of us, 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 an NSF fee of $25.00

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**Patient or Guardian Signature** **Date**

*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:

*Compliance Coordinator*
*11 S Mill St*
*New Castle, PA 16101*
*724.698.2905 compliance@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, 201

## ADA Rights and Responsibilities Statement

**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.***