NEW PATIENT EVALUATION FORM

The following questionaire is a comprehensive look at you and your health. It will take about 15 minutes to complete

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Hello and a Heartfelt Welcome to Our Practice!

We appreciate the trust you have shown in us by selecting our office to care for your dental needs. We will make every effort to see that your dental visit is as comfortable as possible.Your dental concerns come first with us. That is why we stay abreast of new dental techniques and continually improve our professional skills. Most importantly, we are sensitive to the feelings of our patients and encourage open communication.

On your first visit with us, you can expect a thorough oral examination including necessary X-rays. Please bring in your last set of Full Mouth X-rays. If they are not of diagnostic quality, or if they are more than three years old, we will take new ones. We will discuss with you how you can help prevent dental disease through good health habits, and do an oral cancer exam. We will listen carefully to your dental concerns and attempt to answer all of your questions thoroughly. Unless you have serious periodontal problems, we will schedule you to have a preventive prophylaxis or “teeth cleaning.”

Unless an emergency comes up, you can expect us to be on time. (We appreciate you being prompt also.) Please print out the new patient forms, fill them out at your convenience, and bring along to your first visit. If you have a dental insurance card, please bring that as well.

We look forward to meeting you! If you have any questions, please feel free to call us at (717) 259-9596.

Your complete oral health is our main concern. Communication is key to helping us give you a happy, healthy smile. We therefore ask that you complete this form in its entirety.

Patient Information

Full Name *

First | Middle | Last

First Name | Middle Name | Last Name

I prefer to be called: *

○ Male ○ Female

Address *

Street address

Street Address

Street Address Line 2

City | State

City | State / Province

xxxxx

Postal / Zip Code

E-mail *

ex: myname@example.com

Phone Number *

xxx – xxx-xxxx

Area Code Phone Number

Pager/Cell # *

xxx – xxx-xxxx

Area Code Phone Number

Work Phone Number (include extension if applicable) *

xxx – xxx-xxxx

Area Code Phone Number

Do you receive text messages? *

- Yes
- No

SS#: *

xxx-xx-xxxx

ex: xxx-xx-xxxx

Birth Date *

mm-dd-yyyy

Date

Age: *

Driver's License Number *

xx-xxx-xxx

Ex: xx-xxx-xxx

Today's Date

05-04-2021

Date

Employer *

Employer Address *

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

How long there? *

Occupation *

Where and when are best times to reach you? *

Whom may we thank for referring you?

First Name

Last Name

Other family members seen by us:

Type here...

Previous/Present Dentist: *

Last Visit Date *

mm-dd-yyyy

Date

Spouse Information

You may skip this section if it does not apply to you. *

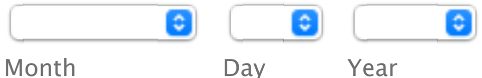
- This apply's to me, continue.
- This does not apply to me, skip.

Name *

First Name

Last Name

Date of Birth *



Month Day Year

Person Responsible for Account

If this does not apply to you, you may skip this section

- I am not responsible for this account, continue
- I am responsible for this account, skip
-

Name

First Name Last Name

Home # *

xxx – xxx-xxxx

Area Code Phone Number

Billing Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Primary Dental Insurance

You may skip this section if it does not apply to you *

- I have Dental Insurance, continue
- I do not have Dental Insurance, skip

Insurance Co. Name: *

Insurance Claims Address *

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Insurance Co. Phone Number *

xxx – xxx-xxxx

Area Code

Phone Number

Group # (Plan, Local or Policy #): *

ex: xxxxxxxxxxxx

Subscriber's Name: *

First Name

Last Name

Subscriber's Birthdate: *

mm-dd-yyyy

Date

Subscriber's ID or Social Security #: *

ex: 23

Employer: *

Secondary Dental Insurance

You may skip this section if it does not apply to you *

- I have Secondary Dental Insurance, continue
- I do not have Secondary Dental Insurance, skip

Insurance Co. Name: *

Insurance Claims Address *

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Insurance Co. Phone Number

xxx – xxx-xxxx

Area Code Phone Number

Group # (Plan, Local or Policy #): *

ex: xxxxxxxxxxxx

Subscriber's Name: *

First Name Last Name

Subscriber's Birthdate: *

mm-dd-yyyy

Date

Subscriber's ID or Social Security #: *

ex: 23

In the event of an emergency, is there someone that we should contact?

Name

First Name Last Name

Relationship

Work Number

xxx – xxx-xxxx

Area Code Phone Number

Home Number

xxx – xxx-xxxx

Area Code Phone Number

Medical History

Do you have a personal physician? *

Yes No

Physician's Name: *

Prefix First Name Last Name

Phone Number *

xxx – xxx-xxxx

Area Code Phone Number

Date of last visit: *

mm-dd-yyyy

Date

Are you currently under the care of a physician? *

Yes No

Please Explain

Type here...

Your current physical health is: *

- Good
- Fair
- Poor

Are you taking any prescription, over-the-counter, or supplement drugs? *

- Yes
- No

Please list each one: *

Type here...

Do you smoke? *

- Yes
- No

Do you use smokeless tobacco? *

- Yes
- No

Have you ever taken Fosamax, Actonel, Boniva, or any other bisphosphonate? *

- Yes
- No

Are you using an oral contraceptive (birth control pills)? *

- Yes
- No

Are you pregnant? *

- Yes
- No

Due Date *

Are you nursing? *

- Yes
- No

Have you ever had any of the following diseases or medical problems?

Artificial Bones/Joints/Valves *

- Yes
- No

Asthma *

- Yes
- No

Cancer/Chemotherapy *

- Yes
- No

Congenital Heart Defect *

- Yes
- No

Diabetes *

- Yes
- No

Difficulty Breathing *

- Yes
- No

Drug/Alcohol Abuse *

- Yes
- No

Epilepsy/Seizures/Fainting Spells *

- Yes
- No

Fever Blisters/Herpes *

- Yes
- No

Heart Attack/Stroke *

- Yes
- No

Heart Murmur *

- Yes
- No

Heart Surgery/Pacemaker *

- Yes
- No

Hemophilia/Abnormal Bleeding *

- Yes
- No

Hepatitis *

- Yes
- No

High/Low Blood Pressure *

- Yes
- No

HIV+/AIDS *

- Yes
- No

Hospitalized for Any Reason *

- Yes
- No

Kidney Problems *

- Yes
- No

Mitral Valve Prolapse *

- Yes
- No

Psychiatric Problems *

- Yes
- No

Rheumatic/Scarlet Fever *

- Yes
- No

Severe/Frequent Headaches *

- Yes
- No

Sickle Cell Disease/Traits *

- Yes
- No

Sinus Problems *

- Yes
- No

Please list any serious medical condition(s) that you have ever had:

Type here...

Are you allergic to any of the following? (Select all that apply) *

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Jewelry/Metals
- ☐ Latex
- ☐ Penicillin
- ☐ I am not allergic to any of the mentioned

Please list any other drugs/materials that you are allergic to:

Type here...

Dental History

Why have you come to the dentist today? *

Type here...

Do you require antibiotics before dental treatment? *

- ○ Yes
- ○ No

Are you currently in pain? *

- ○ Yes
- ○ No

Have you ever had a serious/difficult problem associated with any previous dental work? *

- Yes
- No

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/TMD)? *

- Yes
- No

Your current dental health is: *

- Good
- Fair
- Poor

Do your gums ever bleed? *

- Yes
- No

Have you ever been diagnosed with gum disease or treated for gum disease? *

- Yes
- No

How many times per day do you brush? *

How many times per week do you floss? *

Do you use a manual toothbrush or an electric toothbrush? *

Smile Evaluation

Are you delighted with your smile? *

- Yes
- No

Please rate your smile from 1 to 10 (1 = I dislike my smile, 10 = awesome) *

	1	2	3	4	5	6	7	8	9	10	
Worst											Best

Would you like to have whiter teeth? *

- Yes
- No

If you had a magic wand, what, if anything, would you change about your smile? *

Type here...

How healthy would you like us to get your mouth? (Please select one.) *

- The best it can be
- Average
- My dental health is not a big priority for me

What caused you to leave your last dental office? *

What do you already know about us and what made you choose our

office? *

COMFORT MENU

Your comfort is our priority. We provide a variety of services to ensure that you are comfortable at all times. Please select from the following options:

Patients find that if they take an analgesic prior to treatment it helps later in the day. *

- Tylenol
- Advil
- Other

We provide various levels of sedation to ease your mind. Would you like to discuss the use of a prescribed oral sedative to help ease your mind? *

- Yes
- No

Blankets help keep you warm and relaxed through your visit. Would you like a blanket? *

- Yes
- No

Heated neck wraps keep you comfortable and warm through your visit. Would you like a neck wrap? *

- Yes
- No

Pillows provide an extra measure of comfort if you have a sore back or neck. Would you like a pillow? *

- Yes
- No

We offer a complimentary hand paraffin wax treatment to relax you during your visit. Would you like to take advantage of this service? *

- Yes
- No

We provide headphones and MP3 players for your listening pleasure. Would you like to listen to a MP3 player? *

- Yes
- No

Is there anything else we can do for you to make your visit comfortable?

Please place a check mark in the box next to the statements that concern you or describe your problem. *

- ☐ I gag easily.
- ☐ I feel out of control when I'm lying down in the dental chair.
- ☐ I have not been to the dentist for a long time, and I feel uncomfortable about what you will say about my teeth and my dental hygiene.
- ☐ Pain relief is a top priority for me.
- ☐ I don't like shots (or I've had a bad reaction to shots).
- ☐ Please tell me what I need to know about my mouth in order to make an informed decision. I like to have as much information as possible.
- ☐ My teeth are very sensitive.
- ☐ I don't like the sound of that tool that makes the picking and scraping noise. It is like someone is scratching fingernails on a blackboard.
- ☐ I don't like cotton in my mouth.
- ☐ I hate the noise of the drill.
- ☐ Please respect my time. I don't want to be left sitting in the reception area.
- ☐ I want to know the cost up front. No money surprises please.
- ☐ I have difficulty listening and remembering what I hear while sitting in the dental chair.
- ☐ I have health problems and questions that we need to discuss.

Please read the following carefully

Payment is due in full at the time of treatment unless prior arrangements have been approved.

We appreciate your effort to fill out this complete form. It will ensure that we can provide the most effective care possible. Please do not hesitate to ask if you have any questions. We are here for you.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

We consider our relationship with you to be of primary importance and will always make our recommendations based on what we believe is the very best treatment for you, regardless of your insurance coverage or financial arrangements. For your comfort and convenience, we offer a wide range of financial options and welcome your suggestions and questions.

A) Split Payment (For treatment over $1000)

Half of the total payment is due when appointment is reserved, and the second half is due at preparation visit of the crown/bridges/veneers, etc.

B) Payment Plans

Pay for treatment over 6 to 12 months with no interest or low fixed rates on extended payment plans. Feel free to contact our office for specific details.

C) Prepayment in Full (For treatment over $1000)

A prepayment Bookkeeping Courtesy of 5% will be given for direct payment in full by cash, check, or credit card two business days before the first treatment visit.

Patients with dental benefits:

Your dental benefits are based upon a contract made between your employer and an employee benefits company. If you have any questions regarding your dental benefits, please contact your employer or the benefits carrier directly.

We will submit your claim to your insurance company as a courtesy, as we do not participate with any insurance company. Our office does request payment in full for your estimated portion at the time of service. All outstanding insurance claims are closed 30 days after date of service and any remaining balance is billed to you at the time. If you have dental insurance through Delta and United Concordia, payment in full is collected at the time of service, as your insurance company mails the check directly to you.

Appointment Policy:

We value your time and reserve the appointment time especially for you. Therefore, we kindly request 48 hours notice if you are unable to keep your appointment. If notice is not given, a missed appointment fee may be assessed.

Collections:

I understand that if I become delinquent on my account, my account will be turned over to a collections agency, and a 35% collection fee will be added to the delinquent balance.

FORMS OF PAYMENT ON BALANCES DUE

In order to facilitate access to the very best health care possible, you may choose from any of the following: Cash, Visa, MasterCard, Discover, Money Order, Payment Plan or Personal Check. (A fee of $30.00 is added to all returned checks.) I understand that if I become delinquent on my account, my account will be turned over to a collection agency, and I will subsequently be reported to the credit bureaus. In case of total default, I promise to pay any collection costs and attorney fees incurred to collect on this account. I certify that I have read, fully understand, and accept the above financial policy.

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information

and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

• Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples would be teeth cleaning services, extraction letters, and periodontal or endodontic referrals.

• Payment means such activities as obtaining reimbursement for services, confirming coverage, and obtaining specific benefit information such as benefit maximums and deductibles met, etc., billing or collection activities, and utilization review.

• Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individual identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

• The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

• The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

• The right to inspect and copy your protected health information.

• The right to amend your protected health information.

• The right to receive an accounting of disclosures of protected health information.

• The right to obtain—and we have the obligation to provide—a paper copy of this notice from us at your first delivery of services date.

• The right to provide—and we are obligated to receive—a written acknowledgement that you have received a copy of our Notice of Privacy Protection Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health.

This notice is effective as of April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that our privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of their provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

East Berlin Smiles Dental Center

418 West King Street East Berlin, PA 17316

(717) 259-9596

www.EastBerlinSmiles.com

For more information about HIPAA or to file a complaint:

The U. S. Department of Health & Human Services Office of Civil Rights

200 Independence Avenue, SW Washington, DC 20201 202-619-0257

Toll Free: 1-877-696-6775

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health

information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any

of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office at (717) 259-9596 or by mailing us at 418 West King Street, East Berlin, PA 17316.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address above. Please understand that revocation of this Consent will not affect any action we took before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I understand the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. My signature indicates I have received a copy of the HIPAA law and Dental Materials forms and release East Berlin Smiles to use any dental photographs or videos for lecturing, promotional, or educational purposes.

Name *

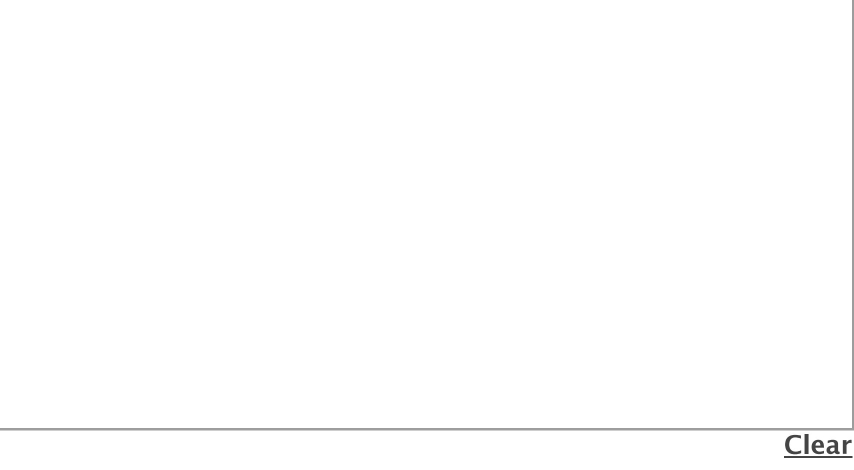
First Name Last Name

Today's Date

05-04-2021

Date

Signature *



Clear

Finish