Pennsylvania Tongue Tie Center

Subsidiary of: East Berlin Smiles

Intake Form

Name *

First Name

Last Name

Email *

example@example.com

Address *

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Date of Birth *

MM-DD-YYYY

Date

Today's Date *

05-04-2021

Date

Preferred Phone Number *

(000) 000-0000

Please enter a valid phone number.

Reason for visit: *

- ◯ Tongue Tie
- ◯ Lip Tie
- ◯ Consult

Parents Names (if patient is a minor)

First Name

Last Name

Parents Date of Birth

MM-DD-YYYY

Date

Dental Insurance

If you do not have Dental Insurance, you may skip this section. *

- ◯ I have dental insurance, proceed
- ◯ 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 Company Phone Number *

(000) 000-0000

Please enter a valid phone number.

Subscriber's Name *

First Name

Last Name

Subscriber's Date of Birth: *

MM-DD-YYYY

Date

Employer: *

Group # *

Subscriber's ID or Social Security # *

Secondary 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 *

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

Subscriber's ID # or Social Security #: *

Employer: *

Who diagnosed your lip/tongue tie? *

Who referred you to our office? *

Pediatrician's Name *

First Name

Last Name

Pediatrician's Phone Number *

(000) 000-0000

Please enter a valid phone number.

Medical History

Has your child had any medical problems?

- Yes
- No

Is your child taking any medications? *

- Yes
- No

Did your child struggle with breastfeeding? *

- ( ) Yes
- ( ) No

Have you ever experienced any of the following? *

- [ ] Speech delay/trouble speaking
- [ ] Choking/Gagging
- [ ] Clenching/Grinding teeth
- [ ] Belly problems (Ex: reflux, gassy)
- [ ] Constipation
- [ ] Neck tension/Posture problems
- [ ] Headaches
- [ ] Chronic ear infections
- [ ] Bedwetting
- [ ] Avoiding textures/meat
- [ ] Dental problems (Cavities)
- [ ] Snoring
- [ ] Drinking a lot of water during meals
- [ ] Scooping food out with fingers
- [ ] Messy eater
- [ ] Loud eater
- [ ] Slow eater
- [ ] Uncontrolled salivation/drooling

Additional Comments *

Type here...

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name

First Name

Last Name

Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Phone Number

(000) 000-0000

Please enter a valid phone number.

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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

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.

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

I name _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my

protected health information to carry out treatment, payment activities, and health care operations.. Please add appropriate fields and text.

Signature of Patient or Parent/Guardian

Clear

Date

05-04-2021

Date

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:

First Name

Last Name

Personal Representative's Name: