PERFECT SMILE DENTAL GROUP ***CIRCLE DESIRED HOME OFFICE: ALTOONA/UNIONTOWN/GREENSBURG/SHADYSIDE/FOREST HILLS/NEW KENSINGTON***

Name _____Male ___ Female ___ Social Security # _____ Date of Birth _____

Address _____ City, Sate, Zip _____

E-mail _____Landline #_____Cell_____Work/Other_____

Emg. Name/Phone _____Parent Name/Phone_____

Dental Insurance Name _____ Phone # _____

Address _____ City, State, Zip _____

Subscriber Name _____ ID#_____DOB_____Employer/Group#_____

Other Dental Insurance _____ Phone #_____

Address _____ City, State, Zip _____

Subscriber Name_____ ID#_____DOB_____Employer/Group#_____

Medical Information

What is your general state of health? Excellent / Good / Fair / Poor Recent hospitalization? (Within 2 years) _____
Are you under the care of a physician? Y / N If YES, Explain: _____ Recent surgery? _____
Primary Care Provider: _____ Phone: _____ Pharmacy: _____ Phone: _____

Are you taking, or have you recently taken any prescriptions or over the counter medications? Y / N If so please list all, including vitamins, minerals, herbal and dietary supplements. _____

Persistent cough greater than 3-week duration? Y / N
Cough that produces blood? Y / N
Been exposed to anyone with tuberculosis? Y / N
Need antibiotics prior to dental treatment? Y / N

WOMEN ONLY: Are you pregnant? Y / N Number of weeks _____
Taking birth control or hormonal replacement? Y / N
Nursing Y / N

Do You Currently Have or Previously Had any of the following conditions:

Abnormal Bleeding	Y / N	Cardiac Pacemaker	Y / N	Headaches / Migraines	Y / N	Psychiatric / Mental Health Care	Y / N
ADHD / Learning Disability	Y / N	Cerebral Palsy	Y / N	Heart Attack	Y / N	Recurrent Infections	Y / N
AIDS / HIV Infection	Y / N	Chemotherapy / Radiation	Y / N	Heart Lesions / Congenital	Y / N	Rheumatic Fever/ Heart Disease	Y / N
Alcohol / Drug Use	Y / N	Chronic Pain	Y / N	Heart Murmur	Y / N	Severe / Rapid Weight Loss	Y / N
Anemia / Blood Disorder	Y / N	Congestive Heart Failure	Y / N	Heart Prosthetic / Bypass	Y / N	Sexually Transmitted Disease	Y / N
Anesthetic Reaction	Y / N	Congenital Heart Disease	Y / N	Hepatitis / Jaundice	Y / N	Shortness of Breath	Y / N
Angina / Heart Disease	Y / N	Damaged Heart Valve	Y / N	High Blood Pressure	Y / N	Sinus Trouble	Y / N
Antibiotic Reaction	Y / N	Development Delays	Y / N	Hives / Skin Rash	Y / N	Sleep Disorders	Y / N
Anger Management Issues	Y / N	Diabetes I or II	Y / N	Joint / Hip Replacement	Y / N	Special Needs Patient	Y / N
Ankles Swelling	Y / N	Dizziness / Fainting Spells	Y / N	Kidney Disease	Y / N	Stroke	Y / N
Anorexia / Bulimia	Y / N	Downs Syndrome	Y / N	Latex Allergy	Y / N	Stomach Ulcers	Y / N
Arteriosclerosis	Y / N	Eating Disorder	Y / N	Liver Disease	Y / N	Swollen Glands (neck)	Y / N
Arthritis / Rheumatoid	Y / N	Emphysema	Y / N	Low Blood Pressure	Y / N	Systemic Lupus Erythematosus	Y / N
Artificial Heart Valve	Y / N	Environmental Allergies	Y / N	Lung Disease	Y / N	Thyroid Disease	Y / N
Asthma / Hay Fever	Y / N	Epilepsy / Seizures	Y / N	Malnutrition	Y / N	Tobacco Use (Any)	Y / N
Autism / Asperger's	Y / N	Excessive Bleeding	Y / N	Mitral Valve Prolapse	Y / N	Tuberculosis	Y / N
Autoimmune Disease	Y / N	Fever Blisters / Herpes	Y / N	Multiple Sclerosis	Y / N	Ulcer / Colitis	Y / N
Blood Clotting Problems	Y / N	Gall Bladder Issues	Y / N	Neurological Disorders	Y / N	Urinate Frequently	Y / N
Blood Transfusion	Y / N	Gastrointestinal Disease	Y / N	Night Sweats	Y / N		
Bronchitis	Y / N	GERD / Heartburn	Y / N	Osteoporosis	Y / N		
Cancer / Tumors	Y / N	Glaucoma	Y / N	Previous Infective Endocarditis	Y / N		

Dental Information

Bleeding Gums	Y / N	Periodontal (Gum) Disease	Y / N	Aspirin	Y / N	Latex	Y / N
Bad Breath / Halitosis	Y / N	Root Canal Treatments	Y / N	Amoxicillin	Y / N	Local Anesthetics	Y / N
Blisters / Ulcers / Sores	Y / N	Sensitive to Hot/Cold/Sweets	Y / N	Ampicillin	Y / N	Metals	Y / N
Dry Mouth	Y / N	Surgery of Mouth / Jaws	Y / N	Barbiturates / Sleeping Pills	Y / N	Penicillin	Y / N
Difficulty Eating	Y / N	TMJ Problems	Y / N	Codeine / Other Narcotics	Y / N	Sulfa	Y / N
Injury to Teeth / Jaw	Y / N	Toothaches	Y / N	Epinephrine	Y / N	Other _____	
Orthodontics (Braces)	Y / N	Tooth Grinding / Clenching	Y / N	Erythromycin	Y / N	_____	
Partials / Dentures	Y / N	Wisdom Teeth Removal	Y / N	Iodine	Y / N	_____	

Allergic Reactions To:

PATIENT DISCLOSURES: I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omission that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Previous Dentist Information

Dentist Name:_____ Date of last visit: _____ X-Rays taken within the last year: _____

HIPAA – PRIVACY PRACTICES

"I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: 1. Treatment (including direct or indirect treatment by other health practitioners involved in my treatment); 2. Obtaining payment from third party payers (e.g. my insurance company); 3. The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my right under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected."

APPOINTMENT POLICY

*It is my responsibility to keep the appointments that I schedule and arrive on time.
*24-hour notice is required for any cancellations.
*Broken appointments and/or appointments cancelled without 24-hour notice may incur a $25 fee for each instance. Further appointments will not be scheduled until fees are paid in full.
*Patients who arrived more than 15 minutes late without notifying the office will be rescheduled for a later date.
* 3 cancellations or no-show appointments without proper notice may result in termination from our practice.

INSURANCE/PAYMENT POLICY

*Payment is due at the time of service. If a procedure requires multiple appointments, payment is required in full at the first appointment unless other arrangements are made.
*Payment options include: Cash, Check, MasterCard, Visa, Novus/Discover, American Express, and CareCredit (upon approval).
*There will be a $30 processing charge for non-sufficient funds or returned checks.
*A charge of $15 will be assessed for release of records. Payment and consent form is due prior to release of records. We require 2 business days to prepare copies.
* Insurance estimates are not a guarantee of payment. **Estimates** are due at the time of service. Patients are responsible for knowing and understanding their insurance. We are not responsible for keeping track of your insurance benefits or maximums. Patients are responsible for any service not paid by insurance. If your insurance does not pay after 60 days, we will bill you directly for the full balance.
*A collection cost of 35% will be added to my balance if my account is sent to collections for non-payment.
*If you are unable to provide proof of insurance you will be required to pay for services rendered at each visit.
*** I hereby assign insurance benefits to be paid directly to Perfect Smile Dental and associates. I hereby agree to directly forward any insurance payments to Perfect Smile Dental that are mailed directly to me within 30 days. I hereby authorize the use of my signature on all insurance submissions.**

IF MINOR PATIENT:

Parent/Guardian First Name:	**Parent/Guardian Last Name:**	**Relationship to Patient:**
Address:	**City/State/Zip:**	**Phone:**
DOB:	**SSN:**	**Driver's License #:**
Employer:	**Occupation:**	**Work Phone:**
Attends School:	**Name of School:**	**School Address:**

*Parents/Guardians accompanying their children are financially responsible for payment. Children are NOT to be seen unless a parent or guardian is present at the appointment. A written consent is required from the parent/guardian if someone else brings the child to their appointment.

PATIENT DISCLOSURE

My signature below affirms that I understand and accept the HIPAA, Appointment, Insurance/Payment Policies as listed on this form.

_____ _____

Patient/Guardian Printed Name **Date**

_____

Patient/Guardian Signature