WEXFORD DENTAL ARTS
General & Aesthetic Dentistry
103 North Meadows Drive - Suite 224 - Wexford, PA 15090 - (724-934-3900)

We are pleased to welcome you to the office of Wexford Dental Arts. Please take a few minutes to fill out both sides of this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date:_____

Home Phone ( ) _____ Cell Phone: _____

Name_____ Social Security # _____

Address_____._____ City_____State____ Zip_____

Sex : ❒ Male ❒ Female Age ____ Birthdate_____ ❒ Maried ❒ Widowed ❒ Single ❒ Minor

Patient Employer/School:_____ Occupation: _____

Employer/School Address: _____ Employer/School Phone: _____

Whom may we thank for referring you? _____ Drivers License:_____

In case of emergency who should be notified? _____ Phone #: _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____

Last Name First Name Middle

Relation to Patient_____ Birthdate _____ Social Security #_____

Address (If different from patient's)_____

City _____ _____State_____ Zip _____

Person Responsible Employed by_____ Occupation: _____

Business Address_____ Business Phone: _____

Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

Names of other dependents covered under this plan: _____

SECONDARY DENTAL INSURANCE

Is patient covered by additional insurance? ❒ Yes ❒ No Relation to Patient _____

Subscriber Name_____ _____ Birthdate:_____ Phone: _____

Address (if different from patients)_____

City _____State:_____ Zip:_____

Subscriber Employed by_____ _____ Business Phone: _____

Insurance Co: _____ Social Security #_____

Contract #_____ Group #_____Subscriber # _____

Names of other dependents covered under this plan: _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____
Former Dentist_____ Date of last dental x-rays _____
Address_____-_____
Check ( ) if you have had problems with any of the following:

❒ Bad Breath
❒ Bleeding gums
❒ Clicking or popping jaw
❒ Food collection between teeth
❒ Grinding teeth
❒ Loose teeth or broken fillings
❒ Periodontal treatment
❒ Sores or growths in your mouth
❒ Sensitivity to hot
❒ Sensitivity to sweets
❒ Sensitivity when biting
❒ Sensitivity to cold

How often do you floss? _____ How often do you brush?_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

MEDICAL HISTORY

For any "Yes" answers, please explain below,

❒ Yes Are you under a physician's care now?
❒ Yes Have you ever been hospitalized or had a major operation?
❒ Yes Have you ever had a serious head or neck injury?
❒ Yes Do you use tobacco?
❒ Yes Do you use controlled substances?
❒ Yes Are you taking any medications, pills or drugs?

_____
_____
_____

Are you allergic to any of the following?
Aspirin Penicillin Codeine Acrylic
Metal Latex Local Anesthetics
Other If yes, please explain:._____

_____
_____

Women:

❒ Yes Are you pregnant or trying to get pregnant?
❒ Yes Taking oral contraceptives?
❒ Yes Nursing?

Do you have, or have you had, any of the following? If you have had a serious illness not listed, check OTHER and explain.

AIDS/HIV Positive
Alzheimer's Disease
Anaphylaxis
Anemia
Angina
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
8lood Transfusion
Breathing Problem
Bruise Easily
Cancer
Chemotherapy
Chest Pains
Cold Sores/Fever Blisters
Congenital Heart Disorder
Convulsions
Cortisone Medicine
Diabetes
Drug Addiction
Easily Winded
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting 5pells/Dizziness
Frequent Cough
Frequent Headaches
Genital Herpes
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Heart Pace Maker
Heart Trouble/Disease
Hemophilia
Hepatitis A
Hepatitis 8 or C
Herpes
High Blood Pressure
Hives or Rash
Hypoglycemia
Irregular Heartbeat
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Pain in Jaw Joints
Radiation Treatments
Recent Weight Loss
Renal Dialysis
Rheumatic Fever
Rheumatism
Scarlet Fever
Shingles
Sinus Trouble
Stomach/Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease
OTHER_____ .

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect informatior can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status. SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE_____

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accounting 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 property confidential. This Act gives you, the patient, the fight to understand and control how your health information is used.

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 thefollowing purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- 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 individually 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, dose personal friends, or any other person identified by you.

We are, however, not required to agree to a written 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 an obligation to provide you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement thatyou have received a copy of our Notice of Privacy 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 information

This notice is effective as of Aprii14,2003 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 the revised Notice of Privacy Practices from this office.

You have recourse if you feel that your 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 the provisions of this notice or the policies and procedures of our office.

Please inform us if you feel you need more information.

Wexford Dental Arts

103 North Meadows Drive

Suite 224

Wexford Pa. 15090

724-934-3900

Patient Acknowledgement of Receipt of Notice of Privacy Practices and

Consent/Limited Authorization of Release Form

You may refuse to sign this acknowledgement and authorization. In refusing we may not be allowed to process your insurance claim. The undersigned acknowledges a receipt of a copy of the currently efiective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS AND FACILITIES IN-THE FUTURE.

Signed _____ **Date**_____

* Insurance is a contract between you and the insurance company. We file claims as a courtesy to our patients. We will assist in disputes between you and your insurance company regarding deductibles, copayments, covered charges, 'usual and customary* charges etc. You are, however, ultimately responsible for the timely payment of your account.

RELEASE OF PAST RECORDS TO WEXFORD DENTAL ARTS

__ Initial I consent to releasing and or transferring my dental/bealth records to Wexford Dental Arts

PREMEDICATION REMINDER

__ Initial I consent to a reminder on Home, Ceil, Recall Card, Voicemarl, and Electronic Confirmations stating 'remember to take your premedication*

MiNOR/CHILD CONSENT

___ Initial I, being the parent or guardian of_____ _____ _ ,do hereby request and authorize the dental staff to perform necessary dental services for my child, inducting but not limited to x-rays and the administration of anesthetics when deemed necessary by the dentist whether or not I am present at the acted appointment when treatment is rendered.

I AUTHORIZE CONTACT FROM THIS OFFICE OR VIA WEAVE TO CONFIRM APPOINTMENTS

I consent to the office leaving a confirmation message on my: PLEASE CHECK ALL THAT APPLY

_____ Voicemail
_____ Text message
_____ Email
_____ Home phone
_____ Cell
_____ Work

1 authorize contact form this office for 'other matters' via; PLEASE CHECK ALL THAT APPLY

_____ Voicemail
_____ Text message
_____ Email
_____ Home phone
_____ Cell
_____ Work

Please LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(this indudes step parents, grandparents, and any care takers who can gave arreia. to this patient's records)

Name:_____ Relationship_____

Name:_____ Relationship_____

Name:_____ Relationship_____

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Patient's Financial and Responsibility Policy

Welcome to our office. We are honored that you have chosen us as your dental health care provider. Quality dental care is a financial investment. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible.

For patients with dental insurance we are happy to work with you to help you understand and maximize your benefit. Insurance companies and coverage can vary. Please remember that your contract for insurance exists between you and your insurance earner.

Payment Options:

- Cash, check, Mastercard®, Visa®, and Discover Card®.
- Convenient Monthly Payment Options1 from CareCredit Healthcare Credit Card

Please note:

- If you have dental insurance, we will be happy to file your claim(s) for you as a courtesy. Ultimately, what insurance does not cover is the responsibility of the patient.
- We may provide an estimate of your liability prior to any appointments for services that cost more than $400 so that you will be financially prepared. Regardless of insurance coverage, you are responsible for your account with our office.
- In the event of a default of payment or after 90 days, a service charge of 1.5 percent per month or 18 percent annually will be added to any outstanding balances not paid within 30 days of the current monthly billing statement. All accounts in which effort to pay is not made will be subject to collection proceedings.
- A fee of $50 is charged for patients who miss or cancel more than 2 times in a calendar year without a 2 business day notice.
- A fee of $20 will be assessed for returned checks.

Thank you for reviewing our financial and insurance policy. We will make every effort to explain your costs to you before treatment so we can avoid misunderstandings and focus on your dental health. If you have any questions, please ask - we are here to serve you.

I have read, understand, and agree to abide by this policy. I have been given the opportunity to receive a copy of this document.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)