Rittenhouse Smiles
Family, Cosmetic, and Implant Dentistry

Welcome to our Practice

PATIENT INFORMATION...

Date _____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. ____ Last Name _____ Nickname _____

Sex: ❑ Male ❑ Female ❑ Other Birth Date _____ Age ____ Soc. Sec. # _____ E-mail _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Home Tel.(_____) _____ Cell.(_____) _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Referred By _____ (FIRST NAME) _____ (LAST NAME) Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ (FIRST NAME) _____ (LAST NAME) Medical Doctor _____ (FIRST NAME) _____ (LAST NAME)

Driver's Lic.# _____ Nearest relative not living with you _____ (FIRST NAME) _____ (LAST NAME) Tel.(_____) _____

Employer _____ Bus. Tel.(_____) _____ Occupation _____ # of years employed _____

Personal Payment Type: ❑ Cash ❑ CareCredit ❑ Credit Card

In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

SPOUSE OR OTHER GUARANTOR INFORMATION (if different from above)...

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel.(_____) _____

INSURANCE INFORMATION...

Student: ..... ❑ Full Time ❑ Part Time ❑ Not ..... School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)

Marital Status: .. ❑ Married ❑ Partnered ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ (CITY)

Employed: ..... ❑ Full Time ❑ Part Time ❑ Retired ❑ Not _____ (STATE) _____ (ZIP)

Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY INSURANCE COMPANY...

Employer _____

Business Address _____ City _____ State _____ Zip _____

Business Telephone (_____) _____ Plan _____

Insurance Company Name _____ I.D. # _____

Address _____ City _____ State _____ Zip _____

Group # _____ Group Name _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ Male ❑ Female Birth Date _____ Social Security Number _____

Street _____ City _____

State _____ Zip _____ Telephone (_____) _____

DENTAL INFORMATION...

Reason for today's visit _____ Are you in pain? ❑ Yes ❑ No, For How Long? _____

Please indicate any of the following problems by checking off the corresponding box:

❑ Toothache ❑ Swelling / lumps in mouth ❑ My teeth are sensitive to: ❑ Hot ❑ Cold ❑ Sweets ❑ Biting

MEDICAL HISTORY...

Are you in good health? ❑ Yes ❑ No • Height _____ Weight _____ • Are you under the care of a physician? ❑ Yes ❑ No

Has a physician or previous dentist recommended antibiotic prophylaxis prior to your dental treatment? ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

MEDICAL HISTORY...

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
❑	❑	Rheumatic fever	❑	❑	Mental health problems	❑	❑	Bleeding tendency	❑	❑	Fever blisters / Herpes
❑	❑	High blood pressure	❑	❑	Problems with immune system *(possibly from med. / surg.)*	❑	❑	Blood transfusion	❑	❑	Sexually transmitted diseases
❑	❑	Low blood pressure				❑	❑	Blood disorder	❑	❑	HIV / AIDS
❑	❑	Mitral valve prolapse	❑	❑	Lupus	❑	❑	Bruise easily	❑	❑	Infectious mononucleosis
❑	❑	Heart murmur	❑	❑	Delay in healing	❑	❑	Eye disease / Glaucoma	❑	❑	Shingles
❑	❑	Chest pain / Angina	❑	❑	Hay fever / Sinus problems	❑	❑	Jaundice / Liver disease	❑	❑	Swollen ankles
❑	❑	Heart attack(s)	❑	❑	Snoring	❑	❑	Hepatitis	❑	❑	Arthritis / Joint disease
❑	❑	Irregular heart beat	❑	❑	Sleep apnea / CPAP			*If so, which type*_____	❑	❑	Prosthetic implant
❑	❑	Cardiac pacemaker	❑	❑	Respiratory problems	❑	❑	Gallbladder trouble	❑	❑	Joint replacement
❑	❑	Heart surgery	❑	❑	Tuberculosis	❑	❑	Fainting spells	❑	❑	Osteoporosis / Osteopenia
❑	❑	Damaged heart valves	❑	❑	Emphysema	❑	❑	Convulsions / Epilepsy	❑	❑	Osteonecrosis
❑	❑	Pneumonia / Bronchitis / Chronic cough	❑	❑	Do you smoke *If so, # packs a day*_____	❑	❑	Stroke	❑	❑	Stomach ulcers
						❑	❑	Thyroid trouble	❑	❑	Crohn's disease
❑	❑	Chronic fatigue / Night sweat	❑	❑	Do you use chewing tobacco	❑	❑	Diabetes	❑	❑	Sickle cell anemia
❑	❑	Trouble climbing 1-2 flights of stairs	❑	❑	A history of drug abuse	❑	❑	Low blood sugar	❑	❑	Tumor or growth
❑	❑	Anemia	❑	❑	A history of alcohol abuse	❑	❑	Are you on dialysis	❑	❑	Cancer / Radiation / Chemotherapy
❑	❑	Asthma	❑	❑	Abnormal bleeding	❑	❑	Kidney trouble	❑	❑	Contact lenses

MEDICATION & ALLERGIES...

Are you now taking:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Nerve pills	❑	❑	Pain killers (including aspirin)	❑	❑	Muscle relaxers	❑	❑	Stimulants
❑	❑	Diet pills	❑	❑	Tranquilizers	❑	❑	Insulin	❑	❑	Antidepressants
									❑	❑	Blood thinners (Coumadin,Aspirin)
									❑	❑	Are you taking, or have you ever taken, any bone density meds. or bisphosphonates, such as Fosamax, Boniva, Actonel, IV Zometa, Reclast, Xgeva, Prolia, or Aredia within the past 12 years.

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

MEDICATION	DOSAGE	FREQUENCY

Are you allergic to, or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Penicillin	❑	❑	Sulfa drugs	❑	❑	Local anesthetic (numbing med)	❑	❑	Amoxicillin
❑	❑	Sodium pentothal / Valium / other tranq.	❑	❑	Aspirin	❑	❑	Codeine or other narcotics	❑	❑	Latex
❑	❑	Soy	❑	❑	Eggs / Yolk	❑	❑	Sulfites	❑	❑	**Do you have any known allergies**

Please list any other medication or antibiotic you are allergic to:

MEDICATION / ANTIBIOTIC NAME	MEDICATION / ANTIBIOTIC NAME

Please list any allergies other than drug allergies:

1-4 below for women only: *(Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ❑ Yes ❑ No
2) Expected delivery date: _____
3) Are you nursing? ❑ Yes ❑ No
4) Are you taking birth control pills: ❑ Yes ❑ No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*
X _____ **Reviewed by**
X _____ **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*
X _____ **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ **Signature of patient:** *(Parent or Guardian if Minor)*
X _____ **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*
X _____ **Date**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We are required to abide by the terms of this Notice of Privacy Practices. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time, as well as for any information we receive in the future. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization and Limitations: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication (e.g, home or business phone) to ensure privacy. We are not required to agree to all requests, and we may say "no" if it is not reasonable or would affect your care. If you pay for a service or item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your insurer. We will say "yes" unless a law requires us to share that information.

Marketing Health-Related Services: We will not use your health information for marketing communications or sell your health information without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get electronic or paper copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information. We may say "no" to your request, but we'll tell you why in writing.

Accounting: You can request a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable fee if you ask for another one within 12 months.

Representative: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using our EthicsPoint Help Line which is (888) 366-6034. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.