Horvath Family Dentistry
New Patient Information

Today's Date: _____/_____/______ Whom may we THANK for referring you? ____________________________________

____ I prefer to be called: ____________________
Last Name First Name MI

Birth Date: _____/_____/______ Social Security # ______ - ______ - _______ Single ___ Married ___ Divorced ___ Widowed___

Home Address: ____
Street City/State Zip Code

E-Mail Address: ______________________________________ Cell Phone: ______________________________________

Home Phone: _______________________________________ Work Phone: _____________________________________

Employer: ____ Occupation: _____________________________________

Person Responsible for Account if other than yourself

Name: ____ Relation: _______________________________________

Cell Phone: _______________________________________ Work Phone: ____________________________________

Social Security # ________ - ________ - ___________ Employer: _______________________________________

Billing Address: ____
Street City/State Zip Code

SPOUSE INFORMATION

Name: ___________________________________ Birth Date: _____/_____/______ Social Security # ______ - ______ - ____________

Insurance MUST be completed in FULL in order for an insurance claim to be processed.

PRIMARY DENTAL Insurance Information

Insurance Co. Name: __________________________________

ID # ______________________ Group # ___________________

Subscriber's Name: ____________________________________

Subscriber's Social Security # ________ - _______ - ___________

Subscriber's Birth Date: _______/________/__________

Subscriber's Employer: __________________________________

SECONDARY DENTAL Insurance Information

Insurance Co. Name: __________________________________

ID # ______________________ Group # ___________________

Subscriber's Name: ____________________________________

Subscriber's Social Security # ________ - _______ - ___________

Subscriber's Birth Date: _______/________/__________

Subscriber's Employer: __________________________________

DENTAL HISTORY

Why have you come to the dentist today? ____

How long has it been since your last dental cleaning? ______________________ Your current dental health is: GOOD FAIR POOR

Are you currently in pain?	Yes	No
Do you require antibiotics before dental treatment?	Yes	No
Have you experienced problems associated with previous dental work?	Yes	No
Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/TMD)?	Yes	No

Do you floss daily?	Yes	No
Do you brush daily?	Yes	No
Have you ever had periodontal disease?	Yes	No
Do you have mobility in your teeth?	Yes	No
Are your teeth sensitive to heat, cold, etc.? ___________________		

MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: ____

Phone # ____________________ Date of last visit: ___/___/_____

Your current physical health is: GOOD FAIR POOR

Are you currently under the care of a physician? Yes No

Explain: ____

Do you SMOKE or use tobacco in any other form? Yes No

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Clindamycin
Y	N	Barbiturates	Y	N	Erythromycin
Y	N	Codeine	Y	N	Jewelry/Metals
Y	N	Dental Anesthetics	Y	N	Latex
Y	N	Sedatives	Y	N	Penicillin
Y	N	Tetracycline	Y	N	Sulfa Drugs

Please list additional drugs/materials that cause allergic reactions: ____

Are you taking any of the following?

For women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No Unsure Week # _______ Are you nursing? Yes No

Y	N	Acetaminophen	Y	N	Brilinta	Y	N	Eliquis	Y	N	Revatio
Y	N	Antibiotics	Y	N	Cialis	Y	N	Insulin/Diabetes Drug	Y	N	Steroids/Cortisone
Y	N	Antihistamines	Y	N	Cold Remedies	Y	N	Levitra	Y	N	Thyroid Medicine
Y	N	Aspirin	Y	N	Coumadin	Y	N	Nitroglycerin	Y	N	Tranquilizers
Y	N	Blood Thinners	Y	N	Digitalis/Heart Medication	Y	N	Pradaxa	Y	N	Viagra
Y	N	Blood Pressure Medication	Y	N	Effient	Y	N	Recreational Drugs	Y	N	Xarelto

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? Yes No

IF YES, please list: ____

Do you or have you experienced the following?

Y	N	Abnormal Bleeding	Y	N	Colitis	Y	N	Hay Fever	Y	N	Liver Disease	Y	N	Shingles
Y	N	Alcohol Abuse	Y	N	Congenital Heart Defect	Y	N	Headaches	Y	N	Low Blood Pressure	Y	N	Sickle Cell Disease
Y	N	Anemia				Y	N	Heart Attack	Y	N	Lupus	Y	N	Sinus Problems
Y	N	Arthritis	Y	N	Diabetes	Y	N	Heart Murmur	Y	N	Mitral Valve Prolapse	Y	N	Steroid Therapy
Y	N	Artificial Bones/Joints	Y	N	Difficulty Breathing	Y	N	Heart Surgery	Y	N	Pacemaker	Y	N	Stroke
Y	N	Artificial Valves	Y	N	Drug Abuse	Y	N	Hemophilia	Y	N	Persistent Cough	Y	N	Thyroid Problems
Y	N	Asthma	Y	N	Emphysema	Y	N	Hepatitis	Y	N	Psychiatric Problems	Y	N	Tonsillitis
Y	N	Blood Transfusion	Y	N	Epilepsy	Y	N	Herpes	Y	N	Radiation Treatment	Y	N	Tuberculosis (TB)
Y	N	Cancer	Y	N	Fainting Spells	Y	N	High Blood Pressure	Y	N	Rheumatic Fever	Y	N	Ulcers
Y	N	Chemotherapy	Y	N	Fever Blisters	Y	N	HIV +/ AIDS	Y	N	Scarlet Fever	Y	N	Venereal Disease
Y	N	Chicken Pox	Y	N	Glaucoma	Y	N	Kidney Problems	Y	N	Seizures			

Please list any serious medical condition(s) that you have experienced: ____

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It 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 the necessary dental services I may need.

X ____ Signature

_________/_________/_________ Date

I certify that I am covered by ________________________________ Insurance Company and I assign directly to Horvath Family Dentistry all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. As a courtesy to our patients, we will file your insurance claim and allow you to pay only your deductible or estimated co-payments. We make every effort to give you an accurate estimate of what your portion of our fees will be, based on information provided to us. However, we have no way to guarantee the actual terms of your insurance policy. If for any reason there is a balance remaining after your insurance company's payment, you will be sent a statement and are responsible for the unpaid balance. For your convenience we accept cash, check, Visa, MasterCard, Discover and Care Credit (an interest free payment plan).

It is the sole responsibility of the patient to provide the correct Dental Insurance Carrier (primary and secondary), along with the proper ID Number, Group Number and FULL Subscriber information. If you have a change to your Dental Carrier, it is the responsibility of the patient to provide updated information.

I hereby authorize Horvath Family Dentistry to release all information necessary to secure the payment of benefits. I authorize the signature on all my insurance submissions, whether manual or electronic.

X ____ Signature

_________/_________/_________ Date

PAYMENT IS DUE AT TIME OF SERVICE

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

A fee of $25.00 is charged for patients who miss or cancel more than 1 time in a calendar year without 24-hour notice.

NOTICE OF PRIVACY PRACTICES POLICY

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

Understanding Your Medical Record/Health Information

As your healthcare provider, we will maintain a record of your visit that contains your symptoms, reports of examinations and test results, diagnoses, treatments, correspondence with other providers and plans for future care or treatment.

Your Health Information Rights

Your health record is the physical property of this practice, however, the information it contains belongs to you. You have the following rights and we request that you notify the Privacy Officer of the Practice of your requests for any of these actions:

1. *Request Restrictions:* You have a right to request restrictions on the use of your information
2. *Obtain a Paper Copy of this Notice*: You have a right to receive a paper copy of this Notice
3. *Inspect and Copy:* You have a right to inspect and receive a copy of your health information. If you request a copy of your information, you may be charged a reasonable fee for photocopying, retrieval, labor, postage and supplies used.
4. *Amend*: You have the right to request that we amend your health information
5. *Obtain an Accounting of Disclosures*: You have the right to request an accounting of certain disclosures of information that have been made about you. This listing includes those disclosures of your information other than treatment, payment or healthcare purposes and is within a specified period of up to six years. The first listing of disclosure is provided as a complimentary service to you, but you may be charged a reasonable fee for additional requests made within a twelve-month period.
6. *Request Communications of Your Health Information:* You have the right to request that you receive communications regarding your information in a certain manner or at a certain location
7. *Revoke Your Authorization for Disclosure:* You have the right to revoke an authorization for disclosure of information that was previously given

Our Responsibilities

Our practice is required to:

1. *Confidentiality:* Maintain the privacy of your health information
2. *Provide a copy of this notice:* We will provide you with a copy of this notice of our legal duties and privacy practices with respect to the information we collect and maintain about you
3. Abide by the terms of this notice
4. *Unable to restrict:* We will notify you if we are unable to agree to a requested restriction of your information
5. *Provide alternative means or alternative locations:* We will accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
6. We reserve the right to charge our privacy practices and to make new provisions effective for all protected health information we keep. Should our information practices change, we will notify you of these changes when you return to our office
7. We will not use or disclose your health information without your authorization, except as described in this notice

For More Information

1. If you have a question or would like additional information, you may contact our privacy officer
2. If you have a concern about the privacy of your information, you may contact our privacy officer. Your concerns will be responded to by our practice, but you may also file a complaint with the secretary of Health and Human Services in the U.S. Office of Civil Rights. The privacy officer will supply information about this procedure.

Examples of Disclosures of Information

1. *Treatment:*
    a. We will use your health information for treatment purposes. As an example, information given to a nurse or physician will be recorded in your health record and used to determine the best treatment for you. Members of the healthcare team will document your treatment goals, actions taken and clinical observations
    b. We will provide your other healthcare providers with copies of various reports that will help them to treat you for any subsequent conditions that may arise
2. *Payment:* A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, your diagnoses, treatments and supplies used
3. *Healthcare Operations*: The physicians and members of your healthcare team may use the information to evaluate the quality of care you received as well as the care received by others similar to you. This information will be used to improve the effectiveness of healthcare operations and services we provide.
4. *Business Associates:* There are some services provided through contracts with business associates. As an example, we contract with a company that provides information services for the computer system we operate. When these services are contracted, we may disclose your health information to this business associate so that they can perform the work we require. To protect your health information, the business associate must appropriately safeguard your information
5. *Notification:* We may disclose information to notify or assist in notifying a family member, personal representative or other person responsible for your care, information about your general condition.
6. *Communication with the family:* We will use good judgment in disclosing to a family member or any other person you identify health information relevant to that person's involvement in your care or payment related to your care
7. *Funeral Directors:* We may disclose health information to funeral directors consistent with state law that allows them to carry out their duties
8. *Organ Donation:* If you are an organ donor, we may disclose your information to organizations that help procure, bank or transport organs for tissue donation and transplantation purposes
9. *Marketing:* 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
10. *Food and Drug Administration:* We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post-marketing surveillance information to enable product recalls, repairs or replacement
11. *Workers Compensation:* In accordance with state law, we may disclose health information as is required for processing a claim under worker's compensation
12. *Public Health:* Under Pennsylvania law, we may disclose your health information to the health department in order to prevent or control disease, injury or disability
13. *Law Enforcement:* We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena
14. *Health investigation:* Federal and state laws make provisions for your health information to be released to appropriate health authorities provided that a member of our staff or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise endangered one or more patients, workers or the public
15. *Other disclosures:* All other uses and disclosures of your information will only be made with your written authorization. If you have authorized us to use or disclose information about you, you may revoke this authorization at any time

Acknowledgment of Receipt of Privacy Practices

This notice has been issued and considered effective on the date signed. We will keep this signed form on file for a minimum of six (6) years.

X ____ ___________/___________/___________

Signature of Patient or Personal Relative Date

X ____

Name of Patient or Personal Relative