HANOVER
DENTAL CARE

Patient Information

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____
Social Security #: _____
Phone Number:
Home: _____ Cell: _____ Work: _____
Email: _____

Martial Status: ☐ Married ☐ Single Minor: ☐ Yes ☐ No
Sex: ☐ Male ☐ Female
Employer: _____
Employer Address: _____
If Full Time Student, School Name: _____ Grade: _____
Person Responsible for Account: _____

Insurance Information

Primary Insurance
Name of Insured: _____
Full Address: _____
Phone Number: Home _____ Cell _____ Work _____
Email Address: _____
DOB: _____ Relationship to Patient: _____
Employer: _____ Insurance Company: _____
SS#: _____ Subscriber #: _____ Group #: _____

Secondary Insurance
Name of Insured: _____
Full Address: _____
Phone Number: Home _____ Cell _____ Work _____
Email Address: _____
DOB: _____ Relationship to Patient: _____
Employer: _____ Insurance Company: _____
SS#: _____ Subscriber #: _____ Group #: _____

Emergency Contact

Name: _____
Phone: _____
Relationship to Patient: _____

Over

Authorization

I hereby authorize payment directly to Hanover Dental Care of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Hanover Dental Care to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and medical and dental histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

Patient/ Responsible Party: _____ Date: _____

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Patient /Parent name: _____ **Date of Birth:**_____
Dependents:_____ **Date of Birth:**_____
_____ **Date of Birth:**_____
_____ **Date of Birth:**_____ **Patient**

Patient Treatment and Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health.

The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

Please Note: Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, and CareCredit. Outside financing is available upon request and approval.

Please note: Additional fees will be applied for returned checks. All account balances over 90 days are subject to a $35.00 late fee.

Do you have insurance?

- As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.
- All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. I authorize the release of any information concerning my (or my child's) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

- We ask that you pay the deductible, co-payment and co-insurance, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, Discover, and CareCredit at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Minors accompanied by the parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service.

Unaccompanied Minors: The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or nonemergency treatment may be denied.

Missed Appointment(s) and Cancellations: Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we require at least a 24 hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A charge may be assessed for multiple missed, short notice or cancelled appointments. A $75 charge may be applied for an appointment with the Hygienist and a $100 charge may be applied for a missed appointment in the doctor's schedule. Multiple failed appointments may result in being dismissed from the dental practice.

Consent: I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Patient /Parent name printed:_____

Patient /Parent signature:_____ Date:_____

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Adult Medical and Dental History

Patient Name _____ D.O.B. _____

Emergency Contact (Name/Phone #) _____

Medical History

1. Physician_____ Phone Number_____

2. When was your last physical examination? _____

3. Are you under the care of a physician? ..... □Yes □No

If yes, for what reason(s)? _____

4. Are you presently taking any medications/drugs/pills/herbals/supplements? ..... □Yes □No

If yes, please list: _____

5. (Women) Is there a chance you are pregnant? ..... □Yes □No If yes, anticipated due date? _____

6. Do you take oral contraceptives? ..... □Yes □No

7. Are you allergic/sensitive to: □None □Codeine □Penicillin □Local Anesthetic □Latex □Pine Nuts □Dyes

□Other: _____

8. Do you smoke, chew tobacco, or use E-cigarettes? ..... □Yes □No If yes, please indicate which one(s), daily frequency, and how long? _____

9. Do you have Diabetes? ..... □Yes □No If yes, please indicate: □Type 1 □Type 2 Last HbA1c date and level: _____

10. Do you have, or have you ever had:

Abnormal blood pressure.....	□Yes □No	Heart pacemaker	□ Yes □No
Anemia	□Yes □No	Heart surgery	□Yes □No
Arthritis	□Yes □No	Heart trouble	□Yes □No
Artificial heart valve/stent/graft.....	□Yes □No	Hepatitis (Type __)	□Yes □No
Artificial joint replacements	□Yes □No	HIV positive/AIDS	□Yes □No
Asthma	□Yes □No	Jaundice	□Yes □No
Cancer	□Yes □No	Kidney trouble/Dialysis	□Yes □No
Chemical dependency	□Yes □No	Leukemia	□Yes □No
Chemotherapy/radiation.	□Yes □No	Oral herpetic lesions	□Yes □No
Congenital heart defects	□Yes □No	Treatment w/Bisphosphonates.....	□Yes □No
Corticosteroid treatment	□Yes □No	Psychiatric care	□Yes □No
Epilepsy/seizures	□Yes □No	Rheumatic fever	□Yes □No
Excessive or prolonged bleeding .	□Yes □No	Sexually transmitted infection	□Yes □No
Fainting spells	□Yes □No	Sinus trouble	□Yes □No
Glaucoma	□Yes □No	Stroke	□Yes □No
Hearing impaired	□Yes □No	Thyroid problem	□Yes □No
Heart murmur	□Yes □No	Tuberculosis or Lung Disease	□Yes □No
		Ulcers/GERD	□Yes □No

11. Do you take pre-medication for anything? ..... □Yes □No If you pre-medicate, what for? _____ 12. Have you had any other serious illness, hospitalization or accident? ..... □Yes □No If yes, please explain:

_____

Dental History

1. Former Dentist_____

Address_____ Phone Number_____

2. When did you last visit a dentist? _____When was your last cleaning? _____

X-rays taken? ..... □Yes □No

If yes, □Full Mouth Series □Bitewings □Panoramic

What was done at your last visit? _____

Why did you leave that dentist? _____

Has any dental treatment been recommended to you that you have not had done? _____

3. Are you aware of any dental problems ..... □Yes □No

If yes, please explain: _____

4. Please rate the present condition of your mouth: **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent**

5. Have you ever been treated for gum disease? ..... □Yes □No

If yes, what was done? _____

6. Do you have well water? ..... □Yes □No

7. Is your water fluoridated? ..... □Yes □No

8. Are your teeth sensitive to: □Nothing □Sweet □Cold □Heat □Pressure

9. Please rate the appearance of your smile: **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent**

10. Would you like a whiter smile? ..... □Yes □No

11. Would you like straighter teeth?..... □Yes □No

12. Have you had your teeth straightened/worn braces? ..... □Yes □No

13. Are you concerned with bad breath (malodor)? ..... □Yes □No

14. Are you concerned with snoring or sleep apnea? ..... □Yes □No

15. Are you concerned with grinding or clenching your teeth (bruxism)? ..... □Yes □No

16. Do you wear a bite guard? ..... □Yes □No

17. Are you aware of possible TMJ problems? (Does your jaw joint make noise, lock up, or create pain?) .....□Yes □No

18. Is there anything else that would be valuable for your dentist to know to best care for you?_____

□ I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

□ I authorize the release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist.

□ I have accurately advised my dental care provider of my current health status and any dietary or herbal supplements, medications, and/or drugs (including recreational and over the counter) that I am taking or have taken in the last week.

Patient Signature _____ Date_____

Dentist Signature _____ Date_____

Hanover Dental Care
Dr. Kevin Resh and Associates

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient giving consent

Name:_____

Address:_____

Phone number:_____e-mail_____

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 ("Notice") 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. A copy of our Notice accompanies this Consent. 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, which will contain the changes. Those changes may apply to any of our 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 administrative team at 717-634-5778.

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 practice. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature: I certify that I have read the Notice of Privacy Practices ("Notice"), which contains a more detailed description of the uses and disclosures of my health information and is available at the office. I understand that in accordance with the Health Insurance Portability and Accountability Act of 1996 (also knows by its acronym "HIPPA"), I have certain rights to privacy regarding my protected health information. 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.

Signature:_____Date:_____

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

Personal Representative's name:_____

Relationship to patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

Revocation of Consent:

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my Consent.

Signature:_____Date:_____

HANOVER DENTAL CARE

1700 Baltimore Pike, Hanover, PA 17331
717-634-5778

Web, Social Media, & Photo Release Form

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be used or disclosed:

- Photographs and/or video of Dental Treatments

Person/entity requesting the information and authorized to make the requested use or disclosure:

- Dr. Kevin Resh
- Dr. Justin Haugh
- Dr. Alexandra Krishnan

This information is being requested for the following purpose(s): Patient & Employee Education, Promotion, Marketing, Print or Ads.
This authorization shall remain in effect from the date signed below until 01/01/2050

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

(Patient Name): _____ grants us permission to have his/her dental work and/or photographs posted within our dental practice and/or on our website, social media accounts, video, or slide shows presentations, print ads and all other marketing or advertising efforts that promote our dental practice.

_____ _____

Patient/Guardian/Parent Signature (Over 18years old / patient signature)

Date