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: ____________

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:_________________

Pediatric Medical and Dental History

Patient Name ______________________________ D.O.B. ____________

Parent/Guardian's Name ______________________ Relationship to Child____________

Emergency Contact (Name/Phone #) ______________________________

Medical History

1. Does your child have any current health problems? .... □Yes □No
If yes, please explain: ______________________________
2. Is your child under care of a physician? .... □Yes □No
Name of physician: ______________________________
3. Is your child receiving any prescriptions, herbal, or OTC medications? .... □Yes □No
If yes, what and when? ______________________________
4. Has your child had any serious illness? .... □Yes □No
If yes, what and when? ______________________________
5. Has your child ever had surgery or is surgery contemplated? .... □Yes □No
If yes, please explain: ______________________________
6. Does your child have a heart murmur or any other heart conditions? .... □Yes □No
7. Does your child experience severe or prolonged bleeding? .... □Yes □No
If yes, please explain: ______________________________
8. Does your child have AIDS or has he/she tested HIV positive? .... □Yes □No
9. Has your child tested positive for hepatitis? .... □Yes □No
10. Has your child had a history of nervous disorders? .... □Yes □No
11. Does your child have frequent headaches? .... □Yes □No
If yes, please explain: ______________________________
12. Is your child allergic/sensitive to: □None □Codeine □Penicillin □Local Anesthetic □Latex □Pine Nuts □Dyes □Other: ______________________________
13. Do you have, or have you ever had:

ADD/ADHD........ □Yes □No
Asthma .... □Yes □No
Autism........ □Yes □No
Behavioral problems .... □Yes □No
Cancer .... □Yes □No
Cerebral palsy .... □Yes □No
Developmental delay .... □Yes □No
Diabetes .... □Yes □No
Epilepsy/seizures/fainting .... □Yes □No
Eating disorders .... □Yes □No
Hay fever/seasonal allergies .... □Yes □No
Hearing impaired .... □Yes □No

Hepatitis/jaundice .... □Yes □No
Hospitalizations .... □Yes □No
Kidney infection .... □Yes □No
Liver problems .... □Yes □No
Leukemia .... □Yes □No
Oral herpetic lesions .... □Yes □No
School problems .... □Yes □No
Speech impairments .... □Yes □No
Thyroid problems .... □Yes □No
Rheumatic fever .... □Yes □No
Take pre-medication for anything? .... □Yes □No
If yes, what for? ______________________________

Dental History

1. This is my child's first visit to the dentist. .... □Yes □No
2. When does your child brush his/her teeth?
   □Upon arising □After any food □Right after meals □Before bedtime
3. Do you currently monitor your child's sugar intake in food, snacks, and drinks? .... □Yes □No
4. Does your child receive Fluoride in their drinking water? .... □Yes □No
5. Does your child receive supplemental Fluoride at home? .... □Yes □No
6. Have any cavities been noted in the past? .... □Yes □No
7. Does your child suck his/her thumb or fingers? .... □Yes □No
8. Were any teeth (baby or permanent) removed by extraction? .... □Yes □No
9. Has a space maintainer been recommended? .... □Yes □No
10. Has a space maintainer been placed? .... □Yes □No
11. Has your child had any problem with dental treatment in the past? .... □Yes □No
12. Has anyone in the family, including parents, had orthodontics? .... □Yes □No
13. Has your child ever received a local anesthetic? .... □Yes □No
14. Has your child ever had occlusal sealants? .... □Yes □No

If yes, when? ______________________________

15. Does your child think there is anything wrong with his/her teeth? .... □Yes □No
16. Have there been any injuries to teeth, such as falls, blows, chips, etc.? .... □Yes □No
17. Does your child grind, clench, or brux their teeth? .... □Yes □No

Explain: ______________________________

18. Does your child snore? .... □Yes □No
19. Is there anything else that would be valuable for your dentist to know to best care for your child?. □ Yes □No

Explain: ______________________________

□ 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 child's healthcare, advice, and treatment provided for the purpose of improved treatment outcomes and/or evaluating and administering claims for insurance benefits.

□ I attest to the accuracy of the information on this page and understand that it is my responsibility to inform the Doctor and the office staff of any changes in my child's medical status at the very next appointment, before any further treatment is rendered.

Patient's/Guardian's 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   Date
(Over 18years old / patient signature)