PLEASE COMPLETE AND RETURN TO BUSINESS OFFICE

Personal Information

Name Last First Middle

Address Street or P. O. Box # City State Zip Code

Phone Number: Home: Work:

Pager #: Cell Phone: Email Address:

Age: Yrs. Birth Date Mo. Day Year Birthplace

( ) Married
( ) Unmarried
( ) Separated

Social Security No. (if child, parents) Driver's License No.

Occupation Employer How long employed? Address & Phone No.

Person responsible for bill Age Address Relationship Social Security No.

Driver's License No.

Occupation Employer How long employed?

Employer Address & Phone No.

Insurance Information

Insured Person's Full Name Date of Birth

Social Security Number Relationship to Patient Work Phone

Insurance Company Name Group or Union Name Group or Local Number

Employer's Name Full Address of Employer

Getting to Know You

1. Why did you select our practice?

2. Whom may we thank for referring you?

3. Is another member of your family or relative a patient in our practice?

4. Person to contact for emergency: _____
   Phone: _____

5. When was your last dental visit? _____

6. When was the last time you had complete dental radiographs taken? _____
   Name & Address of last Dentist:

7. Have you ever had any teeth removed? _____
   How long have these teeth been missing? _____
   Have these teeth been replaced? _____
   How? ❒ Bridge ❒ Partial ❒ Denture ❒ Implants

Payments Alternatives

Please check appropriate box:

❒ 1. As a special service to you, we offer a cash courtesy if you pay for your entire treatment plan in full, in advance.

❒ 2. Cash and personal checks are accepted as your treatments are provided.

❒ 3. If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment; another service to you. This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however, that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.

❒ 4. Mastercard, Visa, Discover and American Express

❒ 5. For long term or extended payments, we offer a healthcare financing program, which when you are accepted, will allow extended small monthly payments for the treatment received.

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he or she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.

Signature of Responsible Party Relationship Date

Allegra Print & Imaging 215-969-0500

MEDICAL HISTORY

1. How do you feel about getting and maintaining a healthy mouth? _____
2. How do you feel about the appearance of your teeth? _____
3. If you could change anything about your smile, what would you change? _____
4. Are you having dental problems at this time? ..... ❒ Yes ❒ No
5. Do your gums bleed at any time? ..... ❒ Yes ❒ No
6. Do you feel very nervous about having dental treatment? ..... ❒ Yes ❒ No
7. Have you ever had a bad experience in the dental office? ..... ❒ Yes ❒ No
8. Have you been under the care of a medical doctor during the past two years? ..... ❒ Yes ❒ No
   If yes, for what reason? _____
   Please provide the name, address, and telephone number of your physician.
   _____
9. Have you been a patient in the hospital during the past two years? ..... ❒ Yes ❒ No
   If yes, for what reason? _____
10. Have you taken any medicine or drugs during the past two years? If yes, please list: _____ ❒ Yes ❒ No
11. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, latex, aspirin, codeine, or any drugs or medicines? If yes, please list: _____ ❒ Yes ❒ No
12. Have you ever had excessive bleeding requiring special treatment? ..... ❒ Yes ❒ No
13. Do you use any tobacco products? ..... ❒ Yes ❒ No
14. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ..... ❒ Yes ❒ No
15. Do your ankles swell during the day? ..... ❒ Yes ❒ No
16. Have you lost or gained more than 10 pounds in the last year? ..... ❒ Yes ❒ No
17. Do you use more than 2 pillows to sleep? ..... ❒ Yes ❒ No
18. Do you ever wake up from sleep short of breath? ..... ❒ Yes ❒ No
19. Are you on a special diet? ..... ❒ Yes ❒ No
20. Check any of the following which apply in either past or present:

❒ Heart Valve Prolapse	❒ High Blood Pressure	❒ Cortisone Medication
❒ Heart Failure	❒ Anemia	❒ Arthritis
❒ Heart Disease or Attack	❒ Asthma	❒ Pain in Jaw Joints
❒ Family History of Cardiovascular Disease	❒ Emphysema	❒ X-Ray or Cobalt Treatment
❒ Angina Pectoris (chest pain)	❒ Shortness of Breath	❒ Cancer or Tumors
❒ Rheumatic Fever	❒ Hay Fever	❒ Chemotherapy (Cancer, Leukemia)
❒ Congenital Heart Lesions	❒ Allergies or Hives	❒ Thyroid Disease
❒ Scarlet Fever	❒ Fainting or Dizzy Spells	❒ Glaucoma
❒ Artificial Heart Valve	❒ Epilepsy or Seizures	❒ HIV Positive (AIDS)
❒ Heart Pacemaker	❒ Nervousness	❒ Venereal Disease
❒ Heart Surgery	❒ Psychiatric Treatment	❒ Cold Sores or Fever Blisters
❒ Artificial Joint of Any Type	❒ Any Form of Eating Disorder	❒ Genital Herpes
❒ Diet Medication: Name _____	❒ Recreational Drug Use	❒ Kidney Trouble
❒ Heart Murmur	❒ Drug Addiction /Alcoholism	❒ Diabetes
❒ Bruise Easily	❒ Tuberculosis (TB)	❒ Ulcers
❒ Blood Transfusion	❒ Any Form of Hepatitis	❒ Stroke
❒ Hemophilia	❒ Liver Disease	❒ Birth Control Medication
❒ Sickle Cell Disease	❒ Rheumatism	❒ Pregnant - Due Date _____

21. Do you have any disease, condition or problem not listed? If so, please list. _____ ❒ Yes ❒ No
    _____
    _____
    _____
    _____

CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist(s) of ( ) and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
B. Application of plastic "sealants" to the grooves of the teeth.
C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
D. Replacement of missing teeth with dental prostheses. (bridges, partial dentures, full dentures)
E. Removal (extraction) of one or more teeth.
F. Treatment of diseased or injured oral tissues (hard and/or soft).
G. Use of sedative drugs to control apprehension and/or disruptive behavior.
H. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
I. Use of general anesthesia to accomplish the necessary treatment.

2. I understand that there are risks involved in this treatment and hereby acknowledge that these risk/s will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor/s. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.

4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.

5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

6. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.

7. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instructions of the dentist/s. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his /her auxiliaries must be maintained.

8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Date:_____ **Time:**_____ **AM/PM. File No.**_____

Patient's Name:_____

Name of Parent or Guardian:_____

Relationship to Patient:_____

_____
Signature: Patient or Parent or Guardian

_____
Witness

Financial Agreement for Richboro Family Dentistry, LLC

Whether you are a new patient to our practice or we have had the pleasure of serving you over the years, we would like you to be aware of our financial policies. We are committed to your treatment being a success. Please understand that your bill is part of your treatment.

Patients without Insurance: We expect payment at the time of service. If you prefer, we can assist you in receiving financing through an outside financial institution. We offer **Care Credit**. Please let us know if you would like to use this option.

Patients with Insurance: We will complete and file your insurance claims on your behalf. Every effort will be made to collect the maximum benefits allowed by your insurance company. Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship. We ask that you read your policy carefully. Some or all of the services we provide may not be a covered benefit. We cannot guarantee the payment level that is quoted nor have information on benefits used in any other dental office if used within your plan year. Deductibles and co-insurance (the amount owed after insurance pays its portion), are to be paid at the time of service. We will do our best to give you an estimate of your co-insurance amount. Insurance companies determine payment when the claim is received.

Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. You will be responsible for paying the full balance amount left on the account after your claim has been paid.

Minor Patients: The adult accompanying the minor (under the age of 18) is responsible for the payment on the account. A parent or legal guardian must accompany the minor unless prior arrangements have been made.

Delinquent Balances: Account balances that become delinquent will be referred to a collection service. All referred accounts are marked "Inactive". In order to have your account "Reactivated", and continue to receive dental treatment in our office the delinquent balance and the collection cost must be paid in full.

Missed and Broken Appointments: Time, trained personnel and dental equipment are reserved for each procedure. Missed appointments add to the cost of dental care when reserved facilities are left waiting empty. We request 48 hours advance notice for rescheduling your appointment. We do not charge for missed appointments; however for repeatedly missed appointments without proper notification rescheduling will be on same day availability only.

Forms of Payment: We accept **VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, CASH OR CHECK**. Interest free healthcare financing through **Care Credit** may be available upon approval of credit.

I have read and understand the financial policy of Richboro Family Dentistry. I agree to be responsible for payment and terms of all services rendered on my behalf or my dependent's.

_____ _____

Signature of patient or parent if minor Date

D E N T A L / I N S U R A N C E A U T H O R I Z A T I O N

Richboro Family Dentistry, LLC
130 Almshouse Road, Suite #500
Richboro, PA 18954

SIGNATURE ON FILE

- **I authorize use of this form on all my insurance submissions.**
- **I authorize release of information to all my insurance carriers.**
- **I understand that I am responsible for any unpaid balance.**
- **I authorize my doctors to act as my agents in helping me to obtain payment from my insurance carriers.**
- **I authorize payment directly to my doctors.**
- **I permit a copy of this authorization to be used in place of the original.**

Name: _____
(please print)

Signature: _____ **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.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect APRIL 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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.

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: 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. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

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 copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0._____ for each page, $_____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 the contact information listed at the end of this Notice. 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 or with the U.S. Department of Health and Human Services.

Contact Officer: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____