Welcome

Modern Dental Group Family & Cosmetic Dentistry

Patient Information

Date____
Patient______________________________________
If Minor
Mother's Name____________________________
Father's Name ____________________________
Guardian_________________________________
Address_____________________________________

____
City_________________State________Zip_______
Male ☐ Female ☐ Age_______Birthdate_________
Patient SS #__________________________________
Employer____________________________________
Spouse's Employer_____________________________
Whom may we thank for referring you?__________
____

Dental Information

Primary Insurance

Name of Policy Holder_________________________
Social Security #______________________________
Date of Birth__________________________________
Relationship to Patient________________________
Policy Holder's Employer_______________________
Insurance Company___________________________

Secondary Insurance

Name of Policy Holder_________________________
Social Security #______________________________
Date of Birth__________________________________
Relationship to Patient________________________
Policy Holder's Employer_______________________
Insurance Company___________________________

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with______________________ and assign directly to Dr.________________________all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Phone Numbers

Home_______________________________________
Work_______________________________________
Cell____
E-Mail______________________________________
Spouses Work_________________________________

In Case of Emergency, Contact:

Name_______________________________________
Relationship_________________________________
Home Phone__________________________________
Work/Cell Phone______________________________

Dental History

Reason for today's visit ________________________
____
Former Dentist_________________________________
City, State____________________________________
Date of last dental visit_________________________
Date of last dental x-ray_________________________
How often do you floss?_________________________
How often do you brush?_________________________
Comments_____________________________________
____
____

Please check if you have the following:

Bad Breath	yes ☐	no ☐
Bleeding Gums	yes ☐	no ☐
Burning sensation on tongue	yes ☐	no ☐
Cigarette, pipe, cigar smoking	yes ☐	no ☐
Clicking or popping jaw	yes ☐	no ☐
Dry Mouth	yes ☐	no ☐
Sensitivity when biting	yes ☐	no ☐
Sores or growths in your mouth	yes ☐	no ☐

Cosmetic Concerns

Do you have any questions regarding cosmetic concerns such as:

☐ Teeth Whitening ☐ Crooked Teeth ☐ Unsightly Fillings
☐ Unsightly Crowns ☐ Gaps between teeth
☐ Other____

Medical History

Medical Doctor's Name______________________ Address______________________
What is your general state of health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Have you been in the hospital in the past 2 years for any reason? ☐ no ☐ yes Explain______________
Are you under a physician's care now? ☐ no ☐ yes Explain______________
Are you taking any medications ☐ no ☐ yes Please list:______________
Do you smoke or chew tobacco? ☐ no ☐ yes
Woman: Are you pregnant? ☐ no ☐ yes Nursing? ☐ no ☐ yes Taking birth control pills? ☐ no ☐ yes

Check if you have or had any of the following:

☐ no ☐ yes Epilepsy or seizures
☐ no ☐ yes Fainting or dizziness
☐ no ☐ yes Stroke
☐ no ☐ yes Persistent Cough
☐ no ☐ yes Emphysema/bronchitis
☐ no ☐ yes Tuberculosis/PPD+
☐ no ☐ yes Asthma
☐ no ☐ yes Sinus Problem
☐ no ☐ yes Anemia/Sickle cell
☐ no ☐ yes Hepatitis A, B or C
☐ no ☐ yes Liver Disease
☐ no ☐ yes Irregular heartbeat

☐ no ☐ yes Bruise/bleed easily
☐ no ☐ yes Heart problems/angina
☐ no ☐ yes High blood pressure
☐ no ☐ yes Rheumatic fever
☐ no ☐ yes Heart murmur
☐ no ☐ yes Prosthetic Joints
☐ no ☐ yes Mitral valve prolapse
☐ no ☐ yes Congenital heart lesions
☐ no ☐ yes Heart surgery/attack
☐ no ☐ yes Artificial heart valves
☐ no ☐ yes Kidney problems
☐ no ☐ yes Venereal disease

☐ no ☐ yes Diabetes
☐ no ☐ yes Thyroid disease
☐ no ☐ yes AIDS/HIV+
☐ no ☐ yes Arthritis
☐ no ☐ yes Cancer/radiation therapy
☐ no ☐ yes Do you have any other disease, condition, or illness not listed above?
List______________________
____
____
____

Have you taken any medicine for osteoporosis? (bisphosphonates) ☐ no ☐ yes
Do you have any allergies to medications, metals or latex? ☐ no ☐ yes
Please list:
____
____
____
____

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 Thursday, January 2, 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 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. You 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 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 heath information based on a determination using our professional judgment disclosing only heath information that is directly relevant to the person's involvement in your healthcare. We will also use our processional 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 heath 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 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 $0.25 for each page. $3.00 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 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 our 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: Callie Bax
Telephone: 814-456-0710
Fax: 814-459-2783
E-mail: Office@moderndentalgroup.com
Address: 333 State Street
Suite 310
Erie, PA 16507

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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 acknowledgment could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining acknowledgement
- ❑ Other (Please Specify) ____

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