Patient Information Form

Patient Information:

Last Name:	First Name:	Middle Initial:
DOB:	Age:	Social Security Number:
Address:		
City:	State:	Zip Code:
Wireless Phone:		
Home Phone:		
E-mail:	How did you hear about us?	

Primary Insurance:	Secondary Insurance:
Insurance Carrier:	Insurance Carrier:
Employer:	Employer:
Group Number:	Group Number:
Subscriber Name:	Subscriber Name:
Subscriber SSN:	Subscriber SSN:
Member ID:	Member ID:
DOB:	DOB:

Emergency Contact Information:

Name of Contact:
Phone Number:
Relationship to Patient:
May we communicate information with this individual concerning your care? ☐ Yes ☐ No

Authorization:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any of my health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts. By signing this statement, I am agreeing to responsibility of services not paid in full or part by my dental care payer.

I attest to the accuracy of the information on this page.

Patient or Guardian Signature Date

Dental History:

Reason for today's visit: | Date of last Dental visit:

Former Dentist: | Date of last Dental X-rays:

Please indicate if you current have or have had any of the following. Checking the box indicates "Yes", leaving blank indicates "No".

- ☐ Bad Breath
- ☐ Blisters on Lips or Mouth
- ☐ Burning Sensation on Tongue
- ☐ Chew on One Side of Mouth
- ☐ Cigarette, Pipe, or Cigar Smoking
- ☐ Smokeless Tobacco
- ☐ Dry Mouth
- ☐ Food Collection Between Teeth
- ☐ Clench or Grind Teeth
- ☐ Growths or Sore Spots in Your Mouth
- ☐ Gums Swollen, Tender or Bleeding
- ☐ Head, Neck, Jaw Pain, or Aches
- ☐ Lip or Cheek Biting
- ☐ Loose Teeth or Broken Fillings
- ☐ Mouth Breathing
- ☐ Orthodontic Treatment
- ☐ Nitrous Oxide
- ☐ Periodontal Treatment
- ☐ Sensitivity to Pressure, Cold, Heat or Sweets

Do you have to take pre-medication prior to receiving dental treatment? ☐ Yes ☐ No
If Yes, please explain:

Have you ever had an allergic reaction to Novocaine, local or general anesthetics? ☐ Yes ☐ No
If Yes, please explain:

Have you ever had trouble from previous dental care? ☐ Yes ☐ No
If Yes, please explain:

Medical History:

Physician's Name: | Physician's Address:

Date and reason for last visit:

Please indicate if you current have or have had any of the following. Checking the box indicates "Yes", leaving blank indicates "No".

Allergies
- ☐ Aspirin
- ☐ Latex
- ☐ Penicillin
- ☐ Other Allergies (List Below)

Conditions
- ☐ Abnormal Bleeding
- ☐ Alcohol Use/Consumption
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma:
  Required Hospitalization ☐
  Have you used steroids? ☐
  Date of Last Episode
  _____
- ☐ Bisphosphonates (Fosomax, Actonel, Boniva, Reclast, Didronel, Zometa)
- ☐ Blood disease, Clotting Disorder
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Contact Lenses
- ☐ Cortisone Treatments
- ☐ Cough, Persistent or Bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Any Immune Deficiency
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Pacemaker
- ☐ Pregnant/Nursing:
  Due Date _____
- ☐ Radiation Treatments
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sinusitis
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Sickle Cell Anemia
- ☐ Skin Rash
- ☐ Slow Healing Wounds
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or Growth on Head and/or Neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss, Unexplained
- ☐ Other Conditions (Explain Below)

OTHER ALLERGIES: List all additional allergies you have below.

_____ _____
_____ _____
_____ _____

OTHER CONDITIONS: Explain all additional conditions you have below.

_____
_____
_____

MEDICATIONS: List any medications you are taking below.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Authorization and Release:

I have read and answered the above questions to the best of my knowledge.

_____
Patient/Guardian Signature **Date**

_____
Doctor Signature **Date**

Financial Agreement:

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- All Patients must complete our "Patient Information Form" prior to being seen by the Dental Professional
- Full Payment is due at the time of Service
- We accept CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT
- This Practice provides insurance company billing as a courtesy to our patients. The patient portion of a particular dental service(s) is estimated and due at the time of service.

Adult Patients

- Adult patients are responsible for payment in full at the time of service.

Minors Accompanied by an Adult

- The adult accompanying a minor, his/her parent, or guardians are responsible for payment in full at the time of service

Unaccompanied Minors

- The parents or guardians are responsible for payment in full at time of service. Non – emergency treatment will be denied unless charges have been pre-authorized. Providers may choose to avoid treating a minor without an adult present at his or her own discretion.

Insurance

- This Practice provides insurance company billing as a courtesy to our patients. The patient portion of a particular dental service(s) is estimated and due at the time of the service. This amount maybe subject to adjustment, when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services which can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of the dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by the staff regarding his/her remaining benefit in any such benefit period. The claims we submit to insurance companies indicate that you have assigned those benefits to us. However, if you are paid by the insurance company instead of us, you then become responsible for the total account balance and payment would be expected immediately.
- If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available
- You, as a patient, are always responsible for any charges that are not covered by your insurance.

NSF Fee

- All payment returned due to non-sufficient funds will be subject to a NSF fee of $25.00

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

_____ _____

Patient or Guardian Signature Date

Appointment Cancellation Policy Agreement

Zelienople Smiles is committed to providing all of our patients with exceptional care! To ensure that every patient receives the best possible care, we ask that you schedule a time according to what works best with your schedule so that you can make it to your appointment.

When a patient cancels without giving 24 hours notice or fails to show to their appointment, they prevent another patient from being seen.

If a patient fails to give a 24 hour notice or does not show up for their scheduled appointment, a charge will be applied to your account for $25.

We do hope that you understand and can appreciate our commitment to seeing you and all of our patients!

_____

Patient Signature

_____

Date

Notice of Privacy Policies

Dr. John Avolio
506 South Main Street, Suite 2103
Zelienople, PA 16063
Phone: (724) 453-1200

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights
You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Our Uses and Disclosures
We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, government requests

Your Choices
You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your requests, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, D.C. 20201, calling 1-877-696-6775, or visiting www. Hhs.gov/ocr/privacy/hipaa/complaints/.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures: How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Treat You: We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our Organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information visit:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do Research: We can use or share your information for health research

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy of security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumer/noticepp.html.

Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request in our office.

Other instructions for Notice

- Date of posting: 02/01/2019
- Privacy Officer: Mathew Spady, Phone 301-252-6361
- NOPP 2018 form modified from HHS website

Acknowledgement of Receipt of Notice of Privacy Practices

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Dr. John Avolio
506 South Main Street, Suite 2103
Zelienople, PA 16063
Phone: (724) 453-1200

You May Refuse to Sign This Acknowledgement

I have been provided the opportunity to read and receive a copy of this office's Notice of Privacy Practices.

Patient's Name (please print): _____

Patient Signature: _____

Date: _____

If acknowledgement is by patient's personal representative:
Personal Representative's Name (please print): _____

Relationship to Patient: _____

I certify that I have the legal authority under applicable law to act on behalf of the patient identified above.

Signature of Personal Representative: _____

Date: _____

If you would like a copy of our Notice of Privacy Practice for your personal records, please ask our staff.

It is our office policy not to allow cell phones, video recorders or cameras into our clinical areas; this is to ensure that our patient privacy is kept at all times. We apologize for any inconvenience this may cause.

Medical Information Release Form

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Instructions: Place Initials in appropriate boxes **[ ]** and sign form on bottom

Release of Information

[ ] I authorize the release of information including the diagnosis, records, billing, examination rendered to me and claims information. This information may be release to:

[ ] Spouse _____
[ ] Child(ren) _____
[ ] Other _____

[ ] Information is not to be release to anyone.

Messages

Messages may be left by employees of Dr. John Avolio or an Automated Messaging Service

Please Call:
[ ] My Home
[ ] My Work
[ ] My Cell Phone

If unable to reach me:
[ ] you may leave a detailed message
[ ] you may text a detailed message
[ ] please leave a message asking me to return your call

Emails

[ ] I authorize Dr. John Avolio to email me pictures of the patient(s) and x-rays, appointment reminders, school excuses, and statements and receipts.

Pictures

[ ] I authorize Dr. John Avolio to use pictures of the patient(s) for in office use and on business related social media

Authorization

Name: _____

Date of Birth: _____

Signature: _____

Date: _____

This release of Information will remain in effect until terminated by me in writing.