

Health History Form

Email: _____ Today's Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: <i>Last</i> <i>First</i> <i>Middle</i>	Home Phone: <i>Include area code</i> ()	Business/Cell Phone: <i>Include area code</i> ()
Address: <i>Mailing address</i>	City:	State: Zip:
Occupation:	Height:	Weight: Date of Birth: Sex: M F
SS# or Patient ID:	Emergency Contact:	Relationship: Home Phone: <i>Include area code</i> () Cell Phone: <i>Include area code</i> ()
If you are completing this form for another person, what is your relationship to that person?		
<i>Your Name</i>	<i>Relationship</i>	
Do you have any of the following diseases or problems:	<i>(Check DK if you Don't Know the answer to the question)</i>	Yes No DK
Active Tuberculosis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Persistent cough greater than a 3 week duration.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cough that produces blood.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Been exposed to anyone with tuberculosis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.		

Dental Information *Please mark (X) your responses to the following questions.*

Yes No DK	Yes No DK
Do your gums bleed when you brush or floss?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have earaches or neck pains?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your mouth dry?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you brux or grind your teeth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any periodontal (gum) treatments?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have sores or ulcers in your mouth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you wear dentures or partials?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any problems associated with previous dental treatment?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you participate in active recreational activities?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your home water supply fluoridated?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you drink bottled or filtered water?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of your last dental exam:
If yes, how often? (<i>Check one:</i>) DAILY <input type="checkbox"/> / WEEKLY <input type="checkbox"/> / OCCASIONALLY <input type="checkbox"/>	What was done at that time?
Are you currently experiencing dental pain or discomfort?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of last dental x-rays:
What is the reason for your dental visit today?	
How do you feel about your smile?	

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

Yes No DK	Yes No DK
Are you now under the care of a physician?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Physician Name: _____ Phone: <i>Include area code</i> ()	If yes, what was the illness or problem?
Address/City/State/Zip:	Are you taking or have you recently taken any prescription or over the counter medicine(s)?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are you in good health?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:
Has there been any change in your general health within the past year?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____
If yes, what condition is being treated?	_____
Date of last physical exam:	_____

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

<p><i>(Check DK if you Don't Know the answer to the question)</i></p> <p>Do you wear contact lenses? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date: _____ If yes, have you had any complications? _____</p> <p>Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date Treatment began: _____</p>	<p style="text-align: right;">Yes No DK</p> <p>Do you use controlled substances (drugs)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED</p> <p>Do you drink alcoholic beverages? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, how much alcohol did you drink in the last 24 hours? _____</p> <p>If yes, how much do you typically drink in a week? _____</p> <p>WOMEN ONLY Are you:</p> <p>Pregnant? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Number of weeks: _____</p> <p>Taking birth control pills or hormonal replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Nursing? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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<p>Allergies. Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.</p> <p>Local anesthetics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Aspirin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Penicillin or other antibiotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sulfa drugs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Cocaine or other narcotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;">Yes No DK</p> <p>Metals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Latex (rubber) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Iodine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hay fever/seasonal <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Animals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Food <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<p style="text-align: right;">Yes No DK</p> <p>Artificial (prosthetic) heart valve <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Previous infective endocarditis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged valves in transplanted heart <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congenital heart disease (CHD)</p> <p style="padding-left: 20px;">Unrepaired, cyanotic CHD <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Repaired (completely) in last 6 months <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Repaired CHD with residual defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;">Yes No DK</p> <p>Autoimmune disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatoid arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Systemic lupus erythematosus <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Bronchitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Emphysema <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sinus trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Cancer/Chemotherapy/ Radiation Treatment <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chest pain upon exertion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chronic pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Diabetes Type I or II <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Eating disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Malnutrition <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Gastrointestinal disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>G.E. Reflux/persistent heartburn <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Ulcers <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Thyroid problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Stroke <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;">Yes No DK</p> <p>Glaucoma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hepatitis, jaundice or liver disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Epilepsy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Fainting spells or seizures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Neurological disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, specify: _____</p> <p>Sleep disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you snore? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Mental health disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Specify: _____</p> <p>Recurrent Infections <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Type of infection: _____</p> <p>Kidney problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Night sweats <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Osteoporosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Persistent swollen glands in neck <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe headaches/ migraines <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe or rapid weight loss <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sexually transmitted disease .. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Excessive urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

<p style="text-align: right;">Yes No DK</p> <p>Cardiovascular disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Angina <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arteriosclerosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congestive heart failure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged heart valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart attack <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart murmur <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Low blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>High blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other congenital heart defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;">Yes No DK</p> <p>Mitral valve prolapse <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Pacemaker <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic heart disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Abnormal bleeding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Anemia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Blood transfusion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, date: _____</p> <p>Hemophilia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>AIDS or HIV infection <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Name of physician or dentist making recommendation: _____ Phone: *Include area code*
()

Do you have any disease, condition, or problem not listed above that you think I should know about?

Please explain: _____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

**General Dental Treatment Consent Form
COVID-19 Pandemic**

1. I knowingly and willingly consent to dental treatment by Dr. Tran and any designated associates and employees during the COVID-19 pandemic.
2. I understand that Innovative Dental Health is following CDC guidelines as far as treatment protocols and infection control.
3. I am unaware of being a possible carrier or infected: I confirm that I have not tested positive for COVID-19 in the last 30 days and that I am not presenting with any of the following symptoms of COVID-19:
 - A. Fever or chills
 - B. Cough
 - C. Shortness of breath or difficulty breathing
 - D. Fatigue
 - E. Muscle or body aches
 - F. Headache
 - G. New loss of taste or smell
 - H. Sore throat.
 - I. Congestion or runny nose
 - J. Nausea or vomiting
 - K. Diarrhea
4. Contact with infected: I confirm that I have not knowingly been in close contact defined as 6 feet or less for a duration of fifteen minutes or more with someone who has tested positive for COVID-19 in the last 14 days, or with anyone that has had the above stated symptoms in the last 14 days.
5. Public travel: I confirm that I have not traveled outside of the United States in the past 14 days. I confirm that I have not traveled domestically by commercial airline, bus, or train within the last 14 days.
6. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms yet are still highly contagious. It is impossible to determine who has it and who does not given the current limitations and availability in COVID-19 viral testing. I understand that numerous dental procedures create water spray which is one way the disease is spread. The ultra-fine nature of the spray can linger in the air for hours, which can transmit the COVID-19 virus.
7. Risk of transmission: I understand that due to the frequency of visits of other dental patients, characteristics of the virus, and the characteristics of dental procedures, that I may have an elevated risk of contracting the virus simply by being in a dental office, even though CDC and Pennsylvania Department of Health guidelines are being observed.
8. **INFORMED CONSENT:** I have been given the opportunity to ask any questions regarding the risks of contracting COVID-19 from the dental office and dental procedures. I reaffirm that I am not a carrier of COVID-19 nor infected with COVID-19 to the best of my knowledge. I do voluntarily assume any and all reasonable medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of my treatment as a result of the COVID-19 pandemic. I acknowledge that the nature and purpose of the dental procedures recommended have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient's name (please print)

Signature of patient, legal guardian or authorized representative

Date

Witness to signature

Date

Innovative Dental Health

Marple Commons, 2002 Sproul Road, Suite 100, Broomall, PA 19008
Telephone: 610-325-1670 | E-mail: Smiles@innovativedentalhealth.com

Financial Policy

I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which may include, but not be limited to, x-rays, study models, imagery, and other aids. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended. I also understand that the use of anesthesia carries with it significant risks that have been explained to me.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto.

All returned checks will be subject to a \$50.00 returned check fee. I will pay all costs of collection, including a \$35.00 collection fee, attorney fees and court costs, should such measures become necessary. I will pay a \$35.00 late fee for balances over 30 days past due.

I will pay a fee of \$25.00-\$75.00 for missed appointments, unless canceled 48 hours in advance. Due to the increasing cost of Personal Protective Equipment (PPE), a \$15.00 fee is due at the time of service.

I consent to the dentist's use and disclosure of my health information to my insurance company or managed care company and any agent thereof. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company and/or managed care company to make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether a cell phone or landline) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

Patient Name: _____ Date: ____/____/____

Responsible Party Signature: _____ Date: ____/____/____

Guardian / Responsible Party, if minor: _____ Date: ____/____/____

Responsible Party Signature: _____ Date: ____/____/____

Innovative Dental Health

Marple Commons, 2002 Sproul Road, Suite 100, Broomall, PA 19008
Telephone: 610-325-1670 | E-mail: Smiles@innovativedentalhealth.com

Dental Insurance Information

Who is responsible for this account? _____

Relationship to patient: _____

Name of Insurance Company: _____

Subscriber Name: _____ Subscriber DOB: ____/____/____

Subscriber ID# _____ Subscriber SSN# _____ - ____ - _____

Group# _____ Employer Name: _____

Subscriber's mailing address (if different from Health History form)

Address: _____

City: _____ State: _____ Zip: _____

Contact: Home# _____ Work# _____ Cell# _____

E-Mail: _____

Does patient have additional dental coverage? **Yes** **No**

Secondary Insurance Company: _____

Subscriber Name: _____ Subscriber DOB: ____/____/____

Subscriber ID# _____ Subscriber SSN# _____ - ____ - _____

Group# _____ Employer Name: _____

Contact: Home# _____ Work# _____ Cell# _____

E-Mail: _____

Innovative Dental Health

2002 Sproul Road, Suite 100, Broomall, PA 19008

Telephone: 610-325-1670 | E-mail: Smiles@innovativedentalhealth.com

Assignment of Benefits

I _____ understand that services rendered to me by **Innovative Dental Health** are my financial responsibility and that the provider will bill my medical and dental insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to **Innovative Dental Health** and I understand that I will be fully responsible for any outstanding balance on my account.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to **Innovative Dental Health**, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible, co-insurance and co-payment at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company.

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to **Innovative Dental Health**, within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies.

I authorize the provider to initiate a complaint or file an appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

X

Signature of policy/holder

Communications Consent Form

Patient Name

Date of Birth

Home Phone Number

Cell Phone

Work Phone Number

FAX Number

E-mail Address

FAX Number

I give permission to be contacted in the following manner (please fill in phone numbers and check all that apply):

Leave message with information.

Leave message with call-back number only.

Leave message at home or on the cell phone with the following individuals: (list name(s) and relationship to patient).

Name of Person to Receive Message

Relationship to Patient

Name of Person to Receive Message

Relationship to Patient

Name of Person to Receive Message

Relationship to Patient

Appointment Reminders

Our office uses an automated appointment reminder system to contact you prior to your scheduled appointment. Please indicate your preference as to how we should contact you:

Home Phone

Cell Phone

E-Mail

Written Communication

OK to mail to my home address

OK to send a FAX

OK to send to e-mail

Communication with Other Healthcare Providers

Patient information or medical records may be communicated to other Healthcare Providers or insurance companies if necessary.

Authorization Signatures

Patient Signature

Effective Date

or

Personal Representative Signature

Effective Date

Relationship to Patient

Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my care).
- Obtaining payment from third party payers (e.g., my insurance company).
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient or Legal Representative Signature

Signature of patient or legal representative

Date

Printed name of legal representative

Relationship to patient

I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.

Signature of patient or legal representative

Date

Staff Confirmation

Name of Staff Member Processing Request (Please Print)

Staff Member Signature

Effective Date

Innovative Dental Health

Practice Name Innovative Dental Health
2002 Sproul Road, Suite 100
Broomall, PA 19008
610-325-1670
smiles@innovatedentalhealth.com

Practice Address

Authorization Form for Use and Disclosure of Patient Information

Authorization for Use/Disclosure of Information

Innovative Dental Health

Practice Name

610-325-1670

Phone Number

I voluntarily consent to and authorize the health care provider named above to use or disclose my health information during the term of this Authorization to the recipient(s) that I identify below.

Recipient

I authorize my health care information to be released to the following recipient(s):

Name of Guardian/Representative

City

State

Zip Code

Purpose

I authorize the release of my health information for the following specific purpose:

(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed

- I authorize the release of the following health information: (check the applicable box below)
- All my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.
- Only the following records or types of health information:

Term

I understand that this Authorization will remain in effect:

- From the date of this Authorization until the _____ day of _____ 20 _____
- Until the Provider fulfills this request.
- Until the following event occurs: _____

Refusal to sign/right to revoke

I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at _____ If I change my mind, I understand that I can revoke this authorization by providing a written *Notice of Revocation* to **name** at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice. The revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written *Notice of Revocation*.

Signature

Date

Signature of Witness

Date

Inability to sign/right to revoke

If the individual patient is unable to sign this Authorization, please complete the information below:

Name of Guardian/Representative

Legal relationship

Witness

Date

Innovative Dental Health

Practice Name

2002 Sproul Road, Suite 100

Address

Broomall,

City

PA

State

19008

Zip Code

NOTICE OF PRIVACY PRACTICES

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.

Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), all medical records and other individually identifiable protected health information (PHI) of which we have knowledge must be kept confidential. All PHI used by us or disclosed by us is covered by this Act regardless of whether this PHI is in electronic, oral or paper form. Several new rights are granted to patients under this Act, allowing control over how your PHI is used, how you can access it, and in some cases amend it.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI.

We may be assessed a penalty for any misuse or unauthorized disclosures of your personal health information as regulated by HIPAA.

This Notice of Privacy Practices is effective on 12/15/2020.

We are bound to abide by the terms of this notice and reserve the right to make revisions to this policy. Should revisions be made, you will be notified in writing and a copy of the revised policy will be made available at your request.

Should any breach of unsecured PHI ever occur, we will notify the patient(s) involved within 10 business days of discovery of this breach.

You will be asked to sign a consent form authorizing us to use and disclose your personal health information only for the following purposes, as defined under the Act:

- Treatment means the provision, coordination, or management of health care and related services by one or more healthcare providers, including the coordination of management of health care by a healthcare provider with a third party; consultation between healthcare providers relating to a patient; or the referral of a patient for health care from one healthcare provider to another. An example of this would be a dentist referral to an orthodontist.
- Payment means obtaining reimbursement for the provision of health care; determinations of eligibility of coverage; billing; claims management; collection activities; justification of charges; and disclosure to consumer reporting agencies; protected health information relating to the collection of reimbursements (only certain information may be disclosed). An example of this would be submitting your bill for health care services to your insurance company

- Health care operations are any activity related to covered functions in which we participate in the function of our offices, such as conducting quality assessment activities; protocol development; case management and care coordination; auditing functions; business management and general administrative activities, including implementation of this regulation; customer service evaluations; resolution of grievances; fundraising; and marketing for which an authorization is not required. An example of this would be evaluation customer service given to patients.

We may, without prior consent use or disclose your PHI to carry out treatment, payment or health care operations:

- Directly to you at your request.
- In an emergency treatment situation, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment, if we are required by law to treat you and attempts to obtain consent are unsuccessful, or if we attempt to obtain consent but are unable, due to barriers of communication, but we determine in our professional opinion that treatment is clearly inferred from the circumstances.
- Pursuant to and in compliance with an authorization signed by you.
- Provided that you are informed in advance of the use and disclosure and have the opportunity to agree to or prohibit or restrict the use or disclosure. This may be an oral agreement between us and may include a directory maintained at our facility containing specific information allowed by the Act.

We may de-identify your personal health information by using codes or removing all individually identifiable health information.

All other uses and disclosures will be made only upon securing a written authorization form signed by you. You have the right to revoke this authorization, at any time, upon written notice and we will abide by that request.

However, exception would be any actions already taken, relying on your authorization, and prior to revocation notice.

If you have paid for services out of pocket, in full, and request that we not disclose PHI related solely to these services to a health plan, we will abide by this request except where required by law to make a disclosure.

We may contact you to provide appointment reminders or to inform you about treatment alternatives or other health related benefits or services that may be of interest to you.

A written authorization from you will be required to release the following information:

- Use and disclosure of psychotherapy notes.
- Use and disclosure of PHI for marketing purposes.
- Disclosures that constitute the sale of PHI.
- Other uses and disclosures of PHI not described in this Notice of Privacy Practices.

Under HIPAA, you have the following rights with respect to your protected health information:

- No use or disclosure of genetic information will be released for underwriting purposes.
- You have the right to request restrictions on certain uses and disclosures of protected health information, including restrictions placed upon disclosure to family members, close personal friends, or any other person you may identify. We are, however, not required to agree with a requested restriction.
- You have the right to receive confidential communications of your protected health information, either directly from us or from us by alternative means or from alternative locations.
- You have the right to inspect and copy your protected health information; You may also request your PHI in an electronic format if we use an electronic (paperless) recordkeeping system.
- You have the right to amend PHI, however, this request may be denied under certain circumstances.
- You have the right to receive an accounting of disclosures of your protected health information made by us in the six years prior to the date of the account request.
- You have the right to obtain a paper copy of this notice from us, even if you have already agreed to receive the notice electronically.

If you feel your privacy rights or the provisions of this notice of privacy policies has been violated, you have the right to file a formal written complaint.