

INNOVATIVE DENTAL HEALTH

Marple Commons, 2002 Sproul Road, Suite 100, Broomall, PA 19008
Telephone: 610-325-1670 | Fax: 610-325-1675 | E-mail: Smiles@innovativedentalhealth.com

Date: _____/_____/_____

Name: _____

Address: _____

Home# _____ Cell# _____ Work # _____

E-mail: _____

Emergency Contact Name & Phone Number: _____

Changes in Dental Insurance? Y N if yes, please provide the information below:

Subscriber Name: _____ Subscriber DOB: _____

Name of Ins. Co. _____ ID or SSN: _____

Medical Update

Note: There are many drug and medication incompatibilities, some of which may result in dangerous health problems. Information about your current use of drugs and medication is essential.

Women: Are you taking birth control pills? Yes No

Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills

Are you pregnant? Yes No If yes, when are you due? _____

Are you Nursing? Yes No

Have you ever had an allergic reaction to medication? Yes No

Do you need to be pre-medicated prior to dental care? Yes No

If yes, please check off box.

Aspirin Codeine Latex Penicillin Sulfa Iodine Local Anesthetic

Other _____

Are you currently taking any New Medication(s)?

Have You Ever Had Or Been Treated For:

Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease / Renal Dialysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease / Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple Myeloma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abnormal Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker or Irregular Beats	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteopenia / Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer: Breast / Prostate	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sexually Transmitted Infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough, persistent to bloody	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stomach or Intestinal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fainting or dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumor / growth on head or neck	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weight loss unexplained	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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.

1.

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 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:** ____ / ____ / ____

Health History Reviewed by:

Kim Tran, DMD _____ / _____ / _____

Elliot Ramer, DMD _____ / _____ / _____

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

2.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Person completing the form: _____ **Signature:** _____

If other than patient, indicate relationship: _____ **Date:** ____/____/____

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

3.

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Innovative Dental Health Notice of Privacy Practices. By signing below, I am "only" giving acknowledgement that I have received or have had the opportunity to receive the Notice of Privacy Practices.

Patient Signature: _____ **Date:** ____ / ____ / ____

Financial Policy

- Your portion not covered by insurance, is due at the time of service. You are fully responsible for the timely payments of your account.
- Any quotes of coinsurance given are estimated. You are ultimately responsible for what the insurance company does not pay.
- We accept Cash, Money Order, Cashier's Check, Visa, MasterCard, American Express and Discover Card.

By signing below, I agree to the following:

- *I will pay my coinsurance/amount due at the time of service.*
- *I will pay a fee of \$25-\$75 for missed appointments, unless canceled 48 hours in advance.*
- *I acknowledge that I am responsible for payment in full if my insurance company has not paid the full balance.*
- *I will pay a \$50.00 fee for any returned checks.*
- *I will pay a \$35.00 late fee for balances over 30 days past due.*
- *I will pay all costs of collection, including a \$35.00 collection fee, attorney fees and court costs, should such measures become necessary.*
- *Due to the increasing cost of Personal Protective Equipment (PPE), a \$15.00 fee is due at the time of service.*

Innovative Dental Health reserves the legal right to dismiss any patient at any time from our office for such reasons as frequently missing scheduled appointments or for not following suggested dental treatment (non-compliance).

4.

Patient Name: _____ **Date:** ____ / ____ / ____

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

HIPAA Notice of Privacy Practices

Innovative Dental Health
2002 Sproul Road, Suite 100, Broomall, PA 19008
610-325-1670 | Smiles@innovativedentalhealth.com

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable disease, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement or disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2013, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Jennifer Keith	610-325-1670	Smiles@innovatedentalhealth.com
HIPAA COMPLIANCE OFFICER	Phone	email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgement form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.