NEW PATIENT INFORMATION FORM

PATIENT NAME: _____ Date of Birth: _____

Preferred Name: _____ Male ☐ Female ☐ Non-binary ☐

Address: _____ Social Security Number: _____

Driver's License Number: _____

_____ E-Mail Address: _____

Home Phone: _____

Place of Employment: _____ Work Phone: _____

Cell Phone: _____

Work Address: _____ Best Time to Contact You: _____

**If patient is under 18 years age: Name of Primary Guardian: _____

Best Contact Phone Number: _____

DENTAL INSURANCE

Primary Dental Insurance Company: _____

Claims Address: _____

_____

Insured: _____ SSN#_____Group#_____Date of Birth_____

Place of Employment for the Primary Dental Coverage: _____

Secondary Dental Insurance Company: _____

Claims Address: _____

_____

Insured: _____ SSN#_____Group#_____Date of Birth_____

Place of Employment for the Secondary Dental Coverage: _____

DENTAL HISTORY

What is the primary reason for your visit today? _____

Do you have any of the following?

	Yes	No		Yes	No		Yes	No
Painful Gums	☐	☐	Grinding/Clenching	☐	☐	Growth in Mouth	☐	☐
Swollen Gums	☐	☐	Biting of lips/cheeks	☐	☐	Difficult Jaw Opening	☐	☐
Bleeding Gums	☐	☐	Cold sores	☐	☐	Difficult Jaw Closing	☐	☐
Loose Teeth	☐	☐	Mouth Breathe/Snore	☐	☐	Gag Easily	☐	☐
Cold Sensitivity	☐	☐	Mouth Sores	☐	☐	Pain/Pressure to biting	☐	☐
Other:								

Last Dental Visit_____ Last Cleaning_____ Last X-rays_____

How did you hear about Bellefonte Family Dentistry?

☐ Family/Friends ☐ Social Media ☐ TV/Radio ☐ Newspaper ☐ Mail

Other: _____

PLEASE TURN PAGE OVER TO COMPLETE HEALTH QUESTIONS

MEDICAL HISTORY

Name of Physician: _____ Phone Number: _____
Are you under the care of a physician now? _____
Do you have a history of hospitalization or surgery?_____
Discuss_____
Are you allergic to any medications or substances? Please check appropriate boxes below:

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex Rubber

Other_____

MEDICATIONS

Prescriptions	Over-the-Counter (including vitamins/supplements)

Do you now have or have you ever had any of the following? Please check {x} appropriate boxes.

	Yes	No		Yes	No		Yes	No
Glaucoma	☐	☐	Snores/Sleep Apnea	☐	☐	HIV // AIDS	☐	☐
Heart Murmur	☐	☐	Rheumatic/Scarlet Fever	☐	☐	Hepatitis A/B/C	☐	☐
Irregular Heartbeat / A-fib	☐	☐	Heart Pacemaker	☐	☐	Psychiatric Treatment	☐	☐
Angina/Chest Pain	☐	☐	High Blood Pressure	☐	☐	Epilepsy/Seizures	☐	☐
Heart Attack/Failure/Surgery	☐	☐	Joint Replacement	☐	☐	Liver Disease	☐	☐
Congenital Heart Disorder	☐	☐	Asthma	☐	☐	Kidney Disease	☐	☐
Mitral Valve Prolapse	☐	☐	Tuberculosis	☐	☐	Diabetes	☐	☐
Artificial Heart Valves	☐	☐	Stroke	☐	☐	A1C Value	☐	☐
Bisphosphonate use? (Osteoporosis meds/injections)				☐	☐			

<u>WOMEN</u> (Please Check) ☐Pregnant/trying to get pregnant ☐Nursing ☐Taking Contraceptives

Have you ever taken premedication before dental appointments? _____
Who should we contact in case of emergency? _____ Phone_____

I am aware of the office policy regarding PRIVACY PRACTICES and have had the opportunity to review this policy and receive a copy if I desire. By my signature below I allow the dentist to discuss my conditions with my physician and request any necessary medical information from him/her. I authorize the dentist to release information about my dental treatment to other health professionals and to insurance companies when needed. I certify that I can read and understand English; the above questions were answered completely without any purposeful false statements.

X_____ _____
Patient Signature (Parent or Guardian) Date

HIPPA

Bellefonte Family Dentistry Notice of Privacy Practices

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether on paper or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. We have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care operations. An example of this would include a dental examination.
- Payment means such activities as obtaining reimbursement for services, confirming insurance coverage, billing or collection activities, and utilization review. An example of this would be filing a claim to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your health information
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain and we have the obligation to provide you a paper copy of the notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

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

This notice is effective as of July 1, 2018 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have the recourse if you feel that your privacy protection have been violated. You have a right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, about violation of the provisions of this notice or the policies and procedures of this office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Richard J. Miller DMD

Privacy Officer

115 S. School St.

Bellefonte, PA 16823

For more information about HIPPA or to file a complaint:

The US Department of Health & Human Services

Office of Civil Rights

200 Independence Ave. SW

Washington DC. 20201

Signature: _____ Date: _____

Bellefonte
FAMILY DENTISTRY

Financial Options and Arrangement

Patient Name: _____ Date:_____

Parent/Guardian: _____ Date:_____

Taking care of you and your family is our top priority. That's why, when it comes to talking about finances, it's very important for us to avoid misunderstandings by being clear with all fees and financial options. The result of this form is a *Financial Agreement* that we ask you to sign and an office representative to sign so that we can both count on clarity in this important matter.

A Returned check fee of $35 will be charged for any check returned for insufficient funds.

At the onset of your treatment, we will provide you with an estimate of the total fees expected. Please understand that it will be an estimate *only.* Treatment sometimes changes for a variety of unforeseen reasons. When it comes to estimating insurance payments or coverage, we must also stress the word estimate, as insurance companies continue to surprise us at times. If the insurance company pays more than expected, you will receive a refund. If they pay less than expected, a balance due will be reflected on your monthly statement. If they deny your eligibility after the fact, the balance becomes your responsibility.

Thank you for reviewing our financial options and indicating your choice of payment. We appreciate the confidence you have placed in us caring for you and your family and remain available to you at any time to assist you with your account. Again, please feel free to contact us with any questions regarding the payment option plans listed on the next page.

Bellefonte
FAMILY DENTISTRY

Plan A: Payment in full

A 5% Courtesy for payment in full at the start of treatment for procedures over $500. For senior patients, those 65 or older and with no dental insurance, we offer a 10% courtesy fee reduction for payment at the time of service.

Plan B: Monthly Payment Plan

For our patients who want to make monthly payments, we offer short and long-term financing through Care Credit. A member of our office staff will gladly assist you with the application process.

Plan C: Insurance Coverage

Our goal is to do whatever it takes to help you maximize your insurance benefits, and as a courtesy, we are happy to bill your dental insurance for services. If your insurance does not pay within 90 days, Bellefonte Family Dentistry reserves the right to request payment in full for services from you and let you collect the insurance funds that are due. This is rare, but it is important for you to recognize that the insurance that you have is a legal contract between *YOU* and your insurance company. Our office is not, and cannot be a part of this contract. Ultimately, you are responsible for all your charges incurred in our office. Please remember that your estimated portion is due in full the day of treatment. You may use one of the other payments plans to pay your portion.

I, _____, have chosen option _____ above, and accept full financial responsibility for this account. I understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment or coverage. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon my dependents in this dental office. Any insurance claim not paid in full after 90 days will become my responsibility to pay at that time.

Also, by signing this form, you give consent to complete any treatment as discussed between you and your dental provider. A treatment plan will be given to you to review prior to starting your dental treatment.

Name (Please Print): _____ Date: _____

Signature Patient/Guardian: _____ Date: _____

Witness Signature: _____ Date: _____

Bellefonte
FAMILY DENTISTRY

HEALTHY SMILE BENEFITS

Because we care about your oral health, we devised an annual discount plan for individual and families that offers all members to receive dental services at affordable prices. Unlike traditional insurance plans, there are zero deductibles and treatment can begin right away. Healthy Smile Benefits coverage begins immediately on plan registration.

Benefits include:

- Simple cleanings (up to two per year).
- Complete annual dental exam (up to two per year)
- Routine X-rays
- A 15% discount on all dental procedures (maximum annual discount of $750 per patient)
- Two complimentary fluoride treatments for children under 18 years of age
- Annual complimentary adult fluoride treatment

A Healthy Smile membership is **$450.00** for an initial plan member... and only $430.00 for each additional family member; which represents a savings of $20.00 per additional member. Eligible family members include spouse/domestic partner and dependent children up to the age of 18 (up to age 21 if dependent child is a full-time student).

Activation of the benefits begins upon payment in full of annual membership and are non-refundable. Membership duration is for one year from registration date. Payment is due in full at time of services rendered in order to receive benefits.

All members of a Healthy Smile family account will have their own anniversary date when the membership was purchased. Should you need financial arrangements for a larger expense, we recommend interest-free payment plans of 3, 6 and 12 months duration are available on request with approved credit through Care Credit. Repayment duration is based on service totals (only $1,000+ charges are applicable for 12mos, 0% interest). When a Care Credit payment plan is used, your Healthy Smile discount will be 5% (versus 15%) due to the 10% financing fee we incur.

Please notify our office at least 48 hours in advance if you must change/cancel a scheduled appointment to avoid a missed appointment fee. Thank you for trusting us with your care. We look forward to making you smile.

115 South School Street, Bellefonte, PA 16823
Phone: 814-355-1587 – Email: office@bellefontefamilydentistry.com

Last Name _____ First _____ MI_____

Home Address _____

City _____ State_____ Zip _____

Home Phone _____ Work Phone _____

Birth Date _____ Employer_____

List covered dependents:

Name	Birth Date	Relationship

Healthy Smile Plan – Total Amount Due _____

Payment Method:

- ☐ Cash
- ☐ Check
- ☐ Credit Card # _____ Exp date _____

Signature _____

Please read and sign below:

Healthy Smile Dental Plan offers significant discounts on dental services. I understand the benefits, limitations, exclusions, and requirements of this plan and agree to the following:
Fees for dental services are due when rendered. Fees for prosthodontic (dentures) and cast restorations (crowns, inlays, onlays, veneers) are due at the preparation/impression visit. If you choose not to pay at the time of service you will be billed our usual and customary fees for such services.

Signature _____ Date _____

Bellefonte
FAMILY DENTISTRY

HEALTHY SMILE BENEFITS New Patients

Because we care about your oral health, we devised an annual discount plan for individual and families that offers all members to receive dental services at affordable prices. Unlike traditional insurance plans, there are zero deductibles, and treatment can begin right away. Healthy Smile benefits coverage begins immediately on plan registration.

Benefits include:

- Simple cleanings (up to two per year).
- Complete annual dental exam (up to two per year)
- Routine x-rays
- A 15% discount on all dental procedures (maximum annual discount of $750 per patient)
- Two complimentary fluoride treatments for children under 18 years of age
- Annual complimentary adult fluoride treatment

A Healthy Smile membership is $550.0 for an initial plan member... and only $500.00 for each additional family member; which represents a savings of $50.00 per additional member. Eligible family members include spouse/domestic partner and dependent children up to the age of 18 (up to age 21 if dependent child is a full-time student).

Activation of the benefits begins upon payment in full of annual membership and are non-refundable. Membership duration is for one year from registration date. Payment is due in full at time of services rendered in order to receive benefits.

All members of a Healthy Smile family account will have their own anniversary date when the membership was purchased. Should you need financial arrangements for a larger expense, we recommend interest-free payment plans of 3, 6 and 12 months duration, which are available on request with approved credit through Care Credit. Repayment duration is based on service totals (only $1000+ charges are applicable for 12mos 0% interest). When a Care Credit payment plan is used, your Healthy Smile discount will be 5% (versus 15%) due to the 10% financing fee we incur.

Please notify our office at least 48 hours in advance if you must change/cancel a scheduled appointment to avoid a missed appointment fee. Thank you for trusting us with your care. We look forward to making you smile.

115 South School Street, Bellefonte, PA 16823
Phone: 814-355-1587 – Email: office@bellefontefamilydentistry.com

Bellefonte
FAMILY DENTISTRY

Last Name _____ First _____ MI_____

Home Address _____

City _____ State_____ Zip _____

Home Phone _____ Work Phone _____

Birth Date _____ Employer_____

Healthy Smile Plan – Total Amount Due -- $

Payment Method:

- ☐ Cash
- ☐ Check
- ☐ Credit Card # _____ Exp date _____

Signature _____

Please read and sign below:

Healthy Smile Dental Plan offers significant discounts on dental services. I understand the benefits, limitations, exclusions, and requirements of this plan and agree to the following:
Fees for dental services are due when rendered. Fees for prosthodontic (dentures) and cast restorations (crowns, inlays, onlays, veneers) are due at the preparation/impression visit. If you choose not to pay at the time of
service you will be billed our usual and customary fees for such services.

Signature _____ Date _____

115 South School Street, Bellefonte, PA 16823
Phone: 814-355-1587 – Email: office@bellefontefamilydentistry.com

Bellefonte
FAMILY DENTISTRY

HEALTHY SMILE+ BENEFITS

Because we care about your oral health, we devised an annual discount plan for individual and families that offers all members to receive dental services at affordable prices. Unlike traditional insurance plans, there are zero deductibles, and treatment can begin right away. Healthy Smile+ benefits coverage begins immediately on plan registration.

Benefits include:

- Periodontal maintenance cleanings (up to three per year).
- More involved cleanings will get a 15% discount
- Complete annual dental exams (up to two per year)
- Routine x-rays
- A 15% discount on all dental procedures (maximum annual discount of $750 per patient)
- Two annual adult fluoride treatments to help protect against cavities and root sensitivity

A Healthy Smile+ membership is $775.00 for each plan member. Activation of the benefits begins upon payment in full of annual membership and are non-refundable. Membership duration is for one year from registration date. Payment is due in full at time of services rendered in order to receive benefits.

All members of a Healthy Smile+ family account will have their own anniversary date when the membership was purchased. Should you need financial arrangements for a larger expense, we recommend interest-free payment plans of 3, 6 and 12 months duration are available on request with approved credit through Care Credit. Repayment duration is based on service totals (only $1000+ charges are applicable for 12mos 0% interest). When a Care Credit payment plan is used, your Healthy Smile+ discount will be 5% (versus 15%) due to the 10% financing fee we incur.

Please notify our office at least 48 hours in advance if you must change a scheduled appointment. Thank you for trusting us with your care. We look forward to making you smile.

115 South School Street, Bellefonte, PA 16823
Phone: 814-355-1587 – Email: office@bellefontefamilydentistry.com

Last Name _____ First _____ MI_____

Home Address _____

City _____ State_____ Zip _____

Home Phone _____ Work Phone _____

Birth Date _____ Employer_____

Healthy Smile+ Plan – Total Amount Due -- $

Payment Method:

- ☐ Cash
- ☐ Check
- ☐ Credit Card # _____ Exp date _____

Signature _____

Please read and sign below:

Healthy Smile+ Dental Plan offers significant discounts on dental services. I understand the benefits, limitations, exclusions, and requirements of this plan and agree to the following:
Fees for dental services are due when rendered. Fees for prosthodontic (dentures) and cast restorations (crowns, inlays, onlays, veneers) are due at the preparation/impression visit. If you choose not to pay at the time of service you will be billed our usual and customary fees for such services.

Signature _____ Date _____

Bellefonte
FAMILY DENTISTRY

HEALTHY SMILE+ BENEFITS New Patients

Because we care about your oral health, we devised an annual discount plan for individual and families that offers all members to receive dental services at affordable prices. Unlike traditional insurance plans, there are zero deductibles, and treatment can begin right away. Healthy Smile+ benefits coverage begins immediately on plan registration.

Benefits include:

- Periodontal maintenance cleanings (up to three per year).
- More involved cleanings will get a 15% discount
- Complete annual dental exams (up to two per year)
- Routine x-rays
- A 15% discount on all dental procedures (maximum annual discount of $750 per patient)
- Two annual adult fluoride treatments to help protect against cavities and root sensitivity

A Healthy Smile+ membership is $900.00 for each plan member. Activation of the benefits begins upon payment in full of annual membership and are non-refundable. Membership duration is for one year from registration date. Payment is due in full at time of services rendered in order to receive benefits.

All members of a Healthy Smile+ family account will have their own anniversary date when the membership was purchased. Should you need financial arrangements for a larger expense, we recommend interest-free payment plans of 3, 6 and 12 months duration, which are available on request with approved credit through Care Credit. Repayment duration is based on service totals (only $1000+ charges are applicable for 12mos 0% interest). When a Care Credit payment plan is used, your Healthy Smile+ discount will be 5% (versus 15%) due to the 10% financing fee we incur.

Please notify our office at least 48 hours in advance if you must change a scheduled appointment. Thank you for trusting us with your care. We look forward to making you smile.

115 South School Street, Bellefonte, PA 16823
Phone: 814-355-1587 – Email: office@bellefontefamilydentistry.com

Bellefonte
FAMILY DENTISTRY

Last Name _____ First _____ MI_____

Home Address _____

City _____ State_____ Zip _____

Home Phone _____ Work Phone _____

Birth Date _____ Employer_____

Healthy Smile+ Plan – Total Amount Due -- $

Payment Method:

- ☐ Cash
- ☐ Check
- ☐ Credit Card # _____ Exp date _____

Signature _____

Please read and sign below:

Healthy Smile+ Dental Plan offers significant discounts on dental services. I understand the benefits, limitations, exclusions, and requirements of this plan and agree to the following:
Fees for dental services are due when rendered. Fees for prosthodontic (dentures) and cast restorations (crowns, inlays, onlays, veneers) are due at the preparation/impression visit. If you choose not to pay at the time of
service you will be billed our usual and customary fees for such services.

Signature _____ Date _____

115 South School Street, Bellefonte, PA 16823
Phone: 814-355-1587 – Email: office@bellefontefamilydentistry.com

Bellefonte
FAMILY DENTISTRY

115 S. School St.

Bellefonte, PA 16823

(814) 355-1587 (Phone Number)

(814) 355-2179 (Fax Number)

Date:_____

Please forward any current x-rays and important information concerning patient, _____

_____ to Bellefonte Family Dentistry. Our office email is smile@bellefontefamilydentistry.com.

Patients Signature: _____ Date: _____

BELLEFONTE FAMILY DENTISTRY

MEDICAL HISTORY FOR SEDATION PATIENTS

Name:_____ Date:_____

Current Weight: _____
Current Height:_____

Name of person picking you up from your appointment:_____

Phone number of person picking you up from your appointment:_____

1. Are you now under a physician's care or have you been during the past 5 years, including hospitalizations(s) and surgery?

   _____
   _____
   _____

2. Are you currently under a doctor's orders or taking any medication(s), including any birth control pills (BCPs), over-the-counter drugs, or homeopathic preparations?

   _____
   _____
   _____

3. Do you have any allergies or are you sensitive to any drugs or substances such as penicillin, Novocain, aspirin, latex, codeine, eggs or soybeans?

   _____
   _____
   _____

4. Have you ever bled excessively after a cut, sound, or surgery? Have you ever received a blood transfusion?

   _____
   _____
   _____

5. Are you subject to fainting, dizziness, nervous disorders, seizures, or epilepsy? Do you have sleep apnea?

   _____
   _____

6. Have you ever had any breathing difficulty, including asthma, emphysema, chronic cough, pneumonia, tuberculosis, or any other lung disorders? Do you use any tobacco products?

_____
_____

7. Have you or your family members ever had any anesthesia-related problems?

_____
_____

8. Do you have heart disease or a history of chest pain or palpations?

_____
_____
_____

9. Is there anything you would like to discuss alone with the doctor?

_____
_____
_____

10. Do you currently use or have a history of using recreational drugs?

_____
_____
_____

_____ _____

Signature of Patient, Parent or Guardian **Date**

For Doctor's Use Only – Core Physical Exam
General Appearance –
Head and Neck –
Intraoral –
Cardiovascular –
Pulmonary –
Neurologic –

Signature of Doctor: Date

_____ _____