KEYSTONE DENTISTRY
YOUR HOMETOWN DENTIST SINCE 1958

New Patient Packet

Patient Information

Patient First Name: | Middle Name: | Last Name: | Address:

City: | State: | Zip Code: | Driver's License #: | Date of Birth: | SSN #:

Email: | Gender: | Marital Status: | Cell Phone: | Home Phone: | Work Phone:

Emergency Contact Name: | Number: | Relationship :

Parent/Guardian Information

First Name* | Last Name* | Date Of Birth* | SSN #* | Phone Number*

Address If Different Than Patient | Who may we thank for inviting you to our office?

Dental Insurance

Policy Holder's First Name: | Policy Holder's Last Name: | Policy Holder's DOB: | Policy Holder's SSN #:

Your Relationship to Policy Holder: | Employer: | Insurance Company Name: | Phone #:

Subscriber ID: | Group #: | Insurance Card - Front | Insurance Card - Back

No File Uploaded | No File Uploaded

Financial Policy

Patient First Name: | Patient Last Name: | Date of Birth:

•FULL PAYMENT IS DUE AT TIME OF SERVICE. •WE ACCEPT CASH, CHECKS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT.

Insurance: Coverage and Co-pays

We provide insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be 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 that 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 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 our team regarding his/her remaining benefit in any such benefit period. For covered services, all co-pays and deductibles must be paid on the day of treatment. Since your insurance company may not cover all costs, we require that you pay any percentage of your balance not paid by your insurance on the day of treatment. For services that are not covered by your insurance, we require that you pay the entire fee the day of your treatment We will attempt to answer any questions we can about your insurance and, to the extent practicable, assist you with insurance billing issues. However, your insurance contract is an agreement between you and your insurance carrier to which we are not a party. In the event that your insurance company does not pay any amounts due for your care, you agree you are financially responsible for such amounts, and that you will pay such amounts due for your care.

Patients Without Insurance

For patients without insurance coverage, you will be responsible for payment on the day of treatment. If you are not able to pay in full, or if your treatment requires several visits, you will be issued an invoice and will be able to discuss payment arrangements with a member of our business office staff.

Cancellation/No Show Policy

A service charge for failed appointments and appointments not cancelled with 24 business hours will be assessed. Currently this fee is $45 and may change from time to time without notice. Multiple no shows will incur a termination of our relationship.

Collections

A charge will be added to your account for any returned checks. You are responsible to pay all costs of collecting, or attempting to collect any debt owed on your account including all attorneys' fees, interest, and late fees.

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

Responsible Party Signature:

Sign

Health History Form

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.

Signature

Sign

Although dental personnel primarily treat the area in and around your mouth your mouth is a part of your entire body. Health problems that you may have or medication that you may be takin g could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?

○ Yes ○ No

If Yes

Have you ever been hospitalized or had a major operation?

○ Yes ○ No

If Yes

Have you ever had a serious head or neck injury?

○ Yes ○ No

If Yes

Are you taking any medications pills or drugs?

○ Yes ○ No

If Yes

Do you take or have you taken Phen-Fen or Redux?

○ Yes ○ No

If Yes

Have you ever taken Fosamax Boniva Actonel or any other medications containing bisphosphonates?

○ Yes ○ No

If Yes

Are you on a special diet?

○ Yes ○ No

If Yes

Do you use tobacco?

○ Yes ○ No

If Yes

Women: Are you...

- ☐ Nursing?
- ☐ Pregnant/Trying to get pregnant?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

- ☐ Acrylic
- ☐ Aspirin
- ☐ Codeine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Metal
- ☐ Penicillin
- ☐ Sulfa Drugs

Do you use controlled substances?

○ Yes ○ No

If Yes

Other?

☐ Yes

Comment

Do you have or have you had any of the following?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above?

○ Yes ○ No

If Yes

Comments:

undefined

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Dental History

How long ago was your last visit to the dentist?

- ○ 1 Month
- ○ 3 Month
- ○ 6 Month
- ○ Last than 1 year
- ○ 1-2 year
- ○ 2-3 year
- ○ 3-5 year
- ○ More than 5 year
- ○ I've never seen a dentist

Name, address, and phone number of previous dentist:

_____

Date of most recent dental exam and dental x-rays:

_____

How did you find us?

- ○ Other Patient
- ○ Friend/Collegue
- ○ Google
- ○ Internet
- ○ Next Door App
- ○ Television Ad
- ○ Other

If you selected other patient, please name the patient here:

_____

I routinely see my dentist every:

- ○ 3 Months
- ○ 4 Months
- ○ 6 Months
- ○ 12 Months
- ○ Not Routinely

Reason for today's visit:

- ☐ Check-up
- ☐ Pain
- ☐ Other

What is your immediate dental concern?

_____

Have you ever had a bad experience at the dentist?

- ○ Yes
- ○ No

If yes, please explain:

_____

Have you had any complications following treatment?

- ○ Yes
- ○ No

If yes, please explain:

_____

Have you had any unfavorable reactions to dental anesthetic?

- ○ Yes
- ○ No

If yes, please explain:

_____

Are your teeth sensitive to cold or hot temperatures?

- ○ Yes
- ○ No

Do you grind your teeth?

- ○ Yes
- ○ No

Are you aware of sores or irritated areas in the mouth?

- ○ Yes
- ○ No

Have you ever been treated for Periodontal or Gum Disease?

- ○ Yes
- ○ No

Does dental treatment make you nervous?

- ○ No
- ○ Yes or Slightly
- ○ Yes or Moderately
- ○ Yes or Extremely

Do your gums bleed when you brush or floss?

- ○ Yes
- ○ No
- ○ Sometime

How often do you brush?

- ○ Never
- ○ Occasionally
- ○ Once a day
- ○ Twice a day
- ○ Three times a day
- ○ Every time I eat

What type of brush do you use?

- ○ Manual
- ○ Electric
- ○ Both

How often do you floss?

- ○ Never
- ○ Occasionally
- ○ Once a day
- ○ Twice a day

How would you rate the condition of your mouth?

- ○ Poor
- ○ Good
- ○ Excellent

Check all that apply:

- ☐ Had complications from past dental treatment
- ☐ Had trouble getting numb
- ☐ Had/have experienced dry mouth
- ☐ Have experience popping and/or clicking of the jaw joint Or or have a limited opening

- ○ Three times a day
- ○ Every time I eat

- ☐ Experienced gum recession
- ☐ Notice teeth becoming more crooked Or crowded Or or overlapped
- ☐ Have any teeth sensitive to biting Or sweets Or or avoid brushing any part of the mouth
- ☐ Have difficulty chewing
- ☐ Wear or have worn a bite appliance or night guard
- ☐ Had any teeth become loose on their own (without injury)
- ☐ Notice spaces developing between teeth
- ☐ Had/have braces Or orthodontic treatment
- ☐ Food gets trapped between any teeth
- ☐ Have whitened or bleached your teeth
- ☐ clench or grind your teeth
- ☐ Noticed an unpleasant taste or odor in your teeth
- ☐ Experienced a burning sensation in the mouth
- ☐ Snore or wake up frequently during the night
- ☐ Notice teeth becoming more loose

Your Smile:

Do you like your smile?

- ○ Yes
- ○ No

If you could change your smile, what would you like to change?

- ☐ Change the color of my teeth
- ☐ change the position or alignment of my teeth
- ☐ Close spaces or restore worn out or broken teeth
- ☐ change the shape of my teeth
- ☐ other

I am interested in:

- ☐ Teeth whitening
- ☐ Straight teeth
- ☐ Replacement of missing teeth
- ☐ White fillings
- ☐ Home care
- ☐ other

To ensure your visit is a great experience, please share any questions or concerns you would like us to know about:

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

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

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, and other government requests • Respond to lawsuits and legal actions

Your Rights

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 request, 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/. • We will not retaliate against you for filing a complaint.

Your Choices

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, you have both the right and choice to tell us to: • Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. 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 see: 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

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.

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 or 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/consumers/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, and on our web site.

Other Instructions for Notice

• This statement is effective as of 10/01/2023. • We never market or sell personal information. • We will never share any protected health records without your written permission.

Consent for Use and Disclosure of Protected Health Information

SECTION A: PATIENT GIVING CONSENT

☐ Initial Acknowledgement of Privacy Practices

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent:

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices:

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: _____ Telephone: _____ Fax: _____ E-mail: _____

☐ I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:

Sign

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

Stop. ONLY complete Section C if you do not Consent.

SECTION C: RIGHT TO REVOKE: Please read carefully before signing

Right to Revoke:

You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature:

Sign

If this Revoke of Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed Consent in the patient's chart.