

Patient Health History

Physician's Name:	Date and reason for last visit:
Physician's Phone:	
Address/City/State/Zip:	List and date any serious injuries, illnesses, operations or hospitalizations below.

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

Allergies <input type="checkbox"/> Aspirin <input type="checkbox"/> Latex <input type="checkbox"/> Penicillin <input type="checkbox"/> Other Allergies (List Below) _____ Conditions <input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> Alcohol Use/Consumption <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis, Rheumatism <input type="checkbox"/> Artificial Heart Valves <input type="checkbox"/> Artificial Joints <input type="checkbox"/> Asthma: Required Hospitalization <input type="checkbox"/> Have you used steroids? <input type="checkbox"/> Date of Last Episode _____ <input type="checkbox"/> Autoimmune disease <input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Blood Clotting Disorder <input type="checkbox"/> Blood Disease	<input type="checkbox"/> Blood Thinners <input type="checkbox"/> Bronchitis <input type="checkbox"/> Cancer <input type="checkbox"/> Chemical/Drug Dependency <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Circulatory Problems <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Cortisone Treatments <input type="checkbox"/> Cough, Persistent or Bloody <input type="checkbox"/> Diabetes: HbA1C _____ Date Taken _____ <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Fainting <input type="checkbox"/> Glaucoma <input type="checkbox"/> Headaches <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Problems <input type="checkbox"/> Hepatitis: Type _____ <input type="checkbox"/> Herpes	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Hormone Imbalance <input type="checkbox"/> Immune Deficiency <input type="checkbox"/> Jaundice <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Mental Health Disorders Specify: _____ <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Neurological Disorders Specify: _____ <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Osteopenia <input type="checkbox"/> Pacemaker <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Pregnant / Nursing Number of weeks: _____ Due Date: _____ <input type="checkbox"/> Radiation Treatments <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Respiratory Disease <input type="checkbox"/> Sexually Transmitted Disease <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Sinusitis <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Skin Rash <input type="checkbox"/> Slow Healing Wounds <input type="checkbox"/> Stroke <input type="checkbox"/> Swelling of Feet or Ankles <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Tumor or Growth on Head and/or Neck <input type="checkbox"/> Ulcer <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Weight Loss, Unexplained <i>*Other Conditions (Explain Below)</i>
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Other Allergies: List all additional allergies you have below.

Other Conditions: List any additional conditions or information below.

Medications: List any medications you are taking below.

Pharmacy Name:	Address/City/State/Zip:
Pharmacy Number:	
Joint Replacement <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had an orthopedic total joint (hip knee, elbow, finger) replacement? If yes, have you had any complications? _____	Bisphosphonates <input type="checkbox"/> Yes <input type="checkbox"/> No Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Boniva, Reclast, Prolia, Didronel, Zometa) for osteoporosis or Paget's Disease?
Do you use controlled substances (drugs)? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please specify what how often below: _____	Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____

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

<input checked="" type="checkbox"/> Patient or Guardian Signature	Date
<input checked="" type="checkbox"/> Doctor Signature	Date

Notice of information and Privacy Practices
HIPAA Communication Form

Patient Name: _____

I have been given a copy of Professional Dental Alliance practice ("Practice"), Notice of Information and Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that the Practice has the right to change this Notice at any time. I may obtain a current copy by contacting the Privacy Officer at (724) 698-2500, or by visiting the Practice's web site.

Patient privacy is important to us. Our policy to keep patient health information confidential and not disclose such information without your consent or written authorization unless otherwise required by federal or state privacy laws.

Please provide us with information with whom we can communicate with concerning you or your child's health information and care. This includes family members, friends, organizations or caregivers and babysitters.

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Please note: If you have someone accompany you in the treatment area, we will assume this person is entitled to receive information regarding your care and we can freely discuss your health information.

Patient Communication - Our practice is to protect the privacy of our patients while ensuring our patients are kept well informed of their appointments and other information. As a service to our patients, we will communicate appointment reminders and other information via text message, email or via phone. Limited information will be left when leaving a voice message. Medical information will not be shared when leaving a voice message. Please inform our team if you would prefer we use an additional communication preference for appointment reminders or other information related to your care. You are free to make changes to your preferences at any time. Updates must be made in person and a new form completed.

My signature below acknowledges that I have been offered and/or provided with a copy of the Notice of Information and Privacy Practices:

Patient or Guardian Signature Date

Print Name and/or Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

Financial Agreement

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

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

Adult Patients

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

Minors Accompanied by an Adult

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

Unaccompanied Minors

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

Insurance

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

NSF Fee

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

Patient or Guardian Signature Date

Professional Dental Alliance and its affiliates comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Professional Dental Alliance and affiliates do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. If requested, Professional Dental Alliance and affiliates provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

If you need these services, contact the Office Manager at the practice location.

If you believe that Professional Dental Alliance and affiliates have failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with:

Compliance Coordinator

11 S Mill St

New Castle, PA 16101

724.698.2905 compliance@nadentalgroup.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kiena P Nutter, Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

V.1 April 19, 201

ADA Rights and Responsibilities Statement

Patient Rights

1. *You have a right to choose your own dentist and schedule an appointment in a timely manner.*
2. *You have a right to know the education and training of your dentist and the dental care team.*
3. *You have a right to arrange to see the dentist every time you receive dental treatment, subject to any state law exceptions.*
4. *You have a right to adequate time to ask questions and receive answers regarding your dental condition and treatment plan for your care.*
5. *You have the right to know what the dental team feels is the optimal treatment plan as well as the right to ask for alternative treatment options.*
6. *You have a right to an explanation of the purpose, probable (*short and long term*) results, alternatives and risks involved before consenting to a proposed treatment plan.*
7. *You have a right to be informed of continuing health care needs.*
8. *You have a right to know in advance the expected cost of treatment.*
9. *You have a right to accept, defer or decline any part of your treatment recommendations.*
10. *You have a right to reasonable arrangements for dental care and emergency treatment.*
11. *You have a right to receive considerate, respectful and confidential treatment by your dentist and dental team.*
12. *You have a right to expect the dental team members to use appropriate infection and sterilization controls.*
13. *You have a right to inquire about the availability of processes to mediate disputes about your treatment.*
14. *You have the right to receive access to treatment and accommodations that are available regardless of race, sex, age, creed, sexual orientation, national origin, religion, handicap, or marital status*

Patient Responsibilities

1. *You have the responsibility to provide, to the best of your ability, accurate, honest and complete information about your medical history and current health status.*
2. *You have the responsibility to report changes in your medical status and provide feedback about your needs and expectations.*
3. *You have the responsibility to participate in your health care decisions and ask questions if you are uncertain about your dental treatment or plan.*
4. *You have the responsibility to inquire about your treatment options and acknowledge the benefits and limitations of any treatment that you choose.*
5. *You have the responsibility for consequences resulting from declining treatment or from not following the agreed upon treatment plan.*
6. *You have the responsibility to keep your scheduled appointments.*
7. *You have the responsibility to be available for treatment upon reasonable notice.*
8. *You have the responsibility to adhere to regular home oral health care recommendations.*
9. *You have the responsibility to assure that your financial obligations for health.*

Areas within the practice may be limited to some requests for accommodations specifically where facility must maintain a sterile environment.