Community Medical and Dental Center

DENTAL PATIENT QUESTIONNAIRE UPDATE

Please answer all questions on **BOTH SIDES** of this form to the best of your ability.

Full Name: _____

Street Address: _____ Town: _____ Zip: _____

Home Phone: (____)_____Cell Phone (____) _____

Work Phone: (____)_____

Dental Insurance Company: _____

policy ID number_____

Are you allergic to any of the following?

Asprin ( ) Penicillin ( ) Any Antibiotics ( ) Codeine ( ) Acrylic ( )

Latex ( ) Metal ( ) Local Anesthetics ( ) Other_____

PLEASE ANSWER YES OR NO TO FOLLOWING QUESTIONS

Are you under physicians care now? ( ) YES ( )NO

Have you been hospitalized or had a major operation since your last visit? ( )YES ( ) NO

NAME OF MEDICATIONS_____

_____

Do you use Controlled substances? ( )YES ( )NO

WOMEN: ARE YOU PREGNANT? ( )YES ( ) NO NURSING? ( )YES ( ) NO

TRYING TO GET PREGNANT? ( )YES ( ) NO TAKING ORAL CONTRACEPTIVES? ( )YES ( )NO

COMPLETE THE OTHER SIDE ALSO

DO YOU CURRENTLY or HAVE YOU EVER HAD ANY OF FOLLOWING: *CIRCLE APPROPRIATE BOX*

YES/NO AIDS/HIV POSITIVE	YES/NO FAINTING	YES/NO MITRAL VALVE PROLAPS
YES/NO ALZHEIMER'S	YES/NO SPELL/DIZZINESS	YES/NO PAIN IN JAW JOINTS
YES/NO ANEMIA	YES/NO FREQUENT COUGH	YES/NO PARATHYROID DISEASE
YES/NO ANGINA	YES/NO FREQUENT DIARRHEA	YES/NO PSYCHIATRIC CARE
YES/NO ARTHRITIS/GOUT	YES/NO FREQUENT HEADACHES	YES/NO RADIATION TREATMENTS
YES/NO ARTIFICIAL JOINT	YES/NO GENITAL HERPES	YES/NO RECENT WEIGHT LOSS
YES/NO ASTHMA	YES/NO GLAUCOMA	YES/NO RENAL DIALYSIS
YES/NO BLOOD DISEASE	YES/NO HAY FEVER	YES/NO RHEUMATIC FEVER
YES/NO BREATHING PROBLEM	YES/NO HEART ATTACK	YES/NO RHEUMATISM
YES/NO BRUISE EASILY	YES/NO HEART MURMUR	YES/NO SCARLET FEVER
YES/NO CANCER	YES/NO HEART PACE MAKER	YES/NO SHINGLES
YES/NO CHEMOTHERAPY	YES/NOHEART/DISEASE/TROUBLE	YES/NO SICKLE CELL DISEASE
YES/NO CHEST PAINS	YES/NO HEMOPHILIA	YES/NO SINUS TROUBLE
YES/NO COLD SORES	YES/NO HEPATITIS A	YES/NO SPINAL BIFIDA
YES/NO CONGENITAL HEART	YES/NO HEPATITIS B OR C	YES/NO STOMACH/INTEST/ DISEASI
YES/NO CONVULSIONS	YES/NO HIGH BLOOD PRESSURE	YES/NO STROKE
YES/NO CORTISONE MEDICINE	YES/NO HIVES OR RASHES	YES/NO SWELLING OF LIMBS
YES/NO DIABETES	YES/NO HYPOGLYCEMIA	YES/NO THYROID DISEASE
YES/NO DRUG ADDICTION	YES/NO IRREGULAR HEART BEAT	YES/NO TONSILLITIS
YES/NO EMPHYSEMA	YES/NO KIDNEY PROBLEMS	YES/NO TUBERCULOSIS
YES/NO EPILEPSY OR SEIZURES	YES/NO LEUKEMIA	YES/NO TUMORS OR GROWTHS
YES/NO EXCESSIVE BLEEDING	YES/NO LIVER DISEASE	YES/NO ULCERS
YES/NO EXCESSIVE THIRST	YES/NO LOW BLOOD PRESSURE	YES/NO VENEREAL DISEASE
	YES/NO LUNG DISEASE	

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE YES( ) NO( )

EXPLAIN_____

_____

_____

_____

_____

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 MY MEDICAL STATUS.

SIGNATURE OF PATIENT, PARENT, OR
GUARDIAN_____DATE_____

COMMUNITY MEDICAL AND DENTAL CENTER, INC
309 GRAVEL PIKE
COLLEGEVILLE, PA 19426

Patient Responsibility

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any dental service or visit, routine examination, xrays, limited exams, emergency exams, restorations or any dental procedures done by the doctor or staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co- payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent.

_____ _____

Printed Patient Name (and Guardian Name if applicable) Patient or Guardian Signature Date

_____

CMDC Witness

I give permission to communicate my Private Healthcare Information to:

_____ _____

COMMUNITY MEDICAL AND DENTAL CENTER, INC.

NOTICE OF PRIVACY PRACTICE (DENTAL NON PROFIT VERSION)

PLEASE REVIEW CAREFULLY AND SIGN.

THIS NOTICE WILL BE KEPT IN YOUR DENTAL FILE

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996("HIPAA") IS A FEDERAL PROGRAM THAT REQUIRES THAT ALL DENTAL RECORDS AND OTHER INDIVIDUAL IDENTIFIABLE DENTAL INFORMATION USED OR DISCLOSED BY USING ANY FORM, WHETHER ELECTRONICALLY, ON PAPER, OR ORALLY ARE KEPT PROPERLY CONFIDENTIAL. THIS ACT GIVES YOU THE PATIENT SIGNIFICANT NEW RIGHTS TO UNDERSTAND AND CONTROL HOW YOUR DENTAL INFORMATION IS USED. "HIPPA" PROVIDES PENALTIES FOR COVERED ENTITIES THAT MISUSE PERSONAL DENTAL INFORMATION.

AS REQUIRED BY "HIPAA" WE HAVE PREPARED THIS EXPLANATION OF HOW WE ARE REQUIRED TO MAINTAIN THE PRIVACY OF YOUR DENTAL INFORMATION AND HOW WE MAY USE AND DISCLOSE YOUR DENTAL INFORMATION.

WE MAY USE AND DISCLOSE YOUR DENTAL RECORDS ONLY FOR EACH OF THE FOLLOWING PURPOSE: TREATMENT, PAYMENT, AND DENTAL CARE OPERATIONS.

1. TREATMENT MEANS PROVIDING, COORDINATING, OR MANAGING DENTAL CARE AND RELATED SERVICES BY ONE OR MORE DENTAL CARE PROVIDERS. AN EXAMPLE OF THIS WOULD INCLUDE TEETH CLEANING SERVICES.
2. PAYMENT MEANS SUCH ACTIVITIES AS OBTAINING REIMBURSEMENT FOR SERVICES, CONFIRMING COVERAGE, BILLING OR COLLECTING ACTIVITIES, AND UTILIZATION REVIEW. AN EXAMPLE OF THIS WOULD BE SENDING A BILL FOR YOUR VISIT TO YOUR INSURANCE COMPANY FOR PAYMENT
3. DENTAL 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 DENTAL INFORMATION BY REMOVING ALL REFERENCES TO INDIVIDUALLY IDENTIFIABLE INFORMATION.

WE MAY CONTACT YOU TO PROVIDE APPOINTMENT REMINDERS OR INFORMATION ABOUT TREATMENT ALTERNATIVES OR OTHER DENTAL-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 ACTIONS RELYING ON YOUR AUTHORIZATION.

YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PROTECTED DENTAL INFORMATION, WHICH YOU CAN EXERCISE BY PRESENTING A WRITTEN REQUEST TO THE PRIVACY OFFICER.

1. THE RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF PROTECTED DENTAL INFORMATION, INCLUDING THOSE RELATED TO DISCLOSURES TO FAMILY MEMBERS, OTHER RELATIVES, CLOSE PERSONAL FRIENDS, OR ANY OTHER 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.
2. THE RIGHT TO REASONABLE REQUESTS TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF PROTECTED DENTAL INFORMATION FROM US BY ALTERNATIVE MEANS OR AT ALTERNATIVE LOCATIONS.
3. THE RIGHT TO INSPECT AND COPY YOUR PROTECTED DENTAL INFORMATION.
4. THE RIGHT TO AMEND YOUR PROTECTED DENTAL INFORMATION.
5. THE RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF PROTECTED DENTAL INFORMATION.
6. THE RIGHT TO RECEIVE A PAPER COPY OF THIS NOTICE FROM US UPON REQUEST.

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF YOUR PROTECTED DENTAL INFORMATION AND TO PROVIDE YOU WITH NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED DENTAL INFORMATION.

THIS NOTICE IS EFFECTIVE AS OF **JANUARY 1, 2020** 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 AND TO MAKE A NEW NOTICE PROVISIONS EFFECTIVE FOR ALL PROTECTED DENTAL INFORMATION THAT WE MAINTAIN. WE WILL POST AND YOU MAY REQUEST A WRITTEN COPY OF REVISED NOTICE FROM THIS OFFICE.

YOU HAVE RECOURSE IF YOU FEEL THAT YOUR PRIVACY PROTECTIONS HAVE BEEN VIOLATED. YOU HAVE THE RIGHT TO FILE A WRITTEN COMPLAINT WITH OUR OFFICE, OR WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF CIVIL RIGHTS, ABOUT VIOLATIONS OF THE PROVISIONS OF THIS NOTICE OR THE POLICIES AND PROCEDURES OF OUR OFFICE. WE WILL NOT RETALIATE AGAINST YOU FOR FILLING A COMPLAINT.

READ AND SIGNED_____ THIS DAY _____(MONTH) _____(YEAR) _____