Community Medical and Dental Center

DENTAL PATIENT QUESTIONNAIRE

Please answer **all questions** on **both sides** of this form to the best of your ability.

Full Name: _____ **Date of Birth**: _____ Marital Status: _____
Street Address: _____ **Town**: _____ **Zip**: _____
Home Phone: (____) _____ **Cell Phone** (____) _____
Work Phone: (____) _____ Occupation : _____
Social Security Number: _____ Name of Spouse: _____
Dental Insurance Company: _____
Policy ID. Number: _____
IF CHILD Mother's Name _____ Previous Dentist: _____
Name of Physician: _____ Phone Number: _____
In Case of Emergency Contact: _____ Phone Number: _____

Are you allergic to any of the following?
Asprin ( ) Penicillin ( ) Any Antibiotics ( ) Codeine ( ) Acrylic ( )
Latex ( ) Metal ( ) Local Anesthetics ( ) Other_____

Please briefly state the reason for your visit:

_____

Dental History

Do you have discomfort in your mouth? ( )YES ( ) NO
Have you had regular dental check- ups ( )YES ( )NO
How long since your last dental visit? _____

Were X-rays taken **of all teeth** at that time?	( )YES	( )NO
Do your gums bleed, feel tender or irritated?	( )YES	( )NO
Are your teeth sensitive to hot, cold, or sweets?	( )YES	( )NO
Are any teeth loose?	( )YES	( )NO
Do you grind, clench, or grit your teeth?	( )YES	( )NO
Does your jaw ever click or cause pain on opening or closing?	( )YES	( )NO
Have your front teeth separated, creating spaces between them recently?	( )YES	( )NO
Have you ever had any teeth extracted?	( )YES	( )NO
Have you ever worn braces?	( )YES	( )NO
Have you ever had a root canal?	( )YES	( )NO
Have you ever had gum treatments?	( )YES	( )NO
Do you wear dentures or plates?	( )YES	( )NO
Have you experienced any growths or sore spots in your mouth?	( )YES	( ) NO
Do you have an unpleasant taste in your mouth?	( )YES	( )NO

Have you ever had abnormal bleeding from a cut, or after a tooth extraction? ( )YES ( )NO

Do you brush your teeth? ( )YES ( )NO How often do you brush? _____
Do you floss you teeth? ( )YES ( )NO How often do you floss? _____

TURN PAGE AND FILL OUT REVERSE SIDE

FOR DENTIST USE ONLY---------- REVIEW OF MEDICAL AND DENTAL HISTORY

DATE_____ DATE_____ DATE_____
DATE_____
DATE_____ DATE_____ DATE_____

MEDICAL HISTORY

PATIENTS NAME_____ **DATE**_____

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

PLEASE ANSWER YES OR NO TO FOLLOWING QUESTIONS

Are you under physicians care now? ( ) YES ( )NO
Have you ever been hospitalized or had a major operation? ( )YES ( ) NO
Have you ever had a serious head or neck injury? ( )YES ( )NO
Are you taking any medications, pills, or drugs? ( )YES ( )NO
NAME OF MEDICATIONS_____

Do you take, or have you ever taken, Phen-Fen or Redux? ( )YES ( )NO
Are you on a special diet? ( )YES ( )NO **Do you use tobacco?** ( )YES ( )NO
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

DO YOU CURRENTLY HAVE ANY OF FOLLOWING: ***PLEASE CHECK APPROPRIATE BOX***

YES/NO AIDS/HIV POSITIVE	YES/NO FAINTING	**YES/NO MITRAL VALVE PROLAPSE**
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/NO**HEART/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/ DISEASE
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, RAHNS, PA. 19426
PHONE 610 489 1313 FAX 6104895859

AUTHORIZATION TO RECEIVE PAYMENT FOR SERVICES AND/OR TO RELEASE OR RECIEVE WRITTEN/VERBAL INFORMATION

ALL PATIENTS PLEASE FILL THIS FORM OUT

It is necessary to obtain payment for our services from second or third party payers. In order to provide dental treatment and to receive payment for our services it is necessary to exchange information with your insurance company.

It may also be necessary to **send** or **receive** information **from other professionals or agencies** in the course of your dental treatment.
Before we exchange information we need your written authorization.

Any information received will become part of your clinical record.
Information received from other sources cannot be released by CMDC.
Patient name(print) _____ _____
SS#_____Birth date_____

I hereby authorize CMDC to **Send** or **Receive** the information checked below
X-Rays ( ) Treatment notes( ) Treatment notes review( )Treatment evaluation ( )
Dental treatment statement for payment ( )

Specialist (if applicable)_____
Insurance Co._____

I have been informed that I may revoke this authorization at any time by writing to CMDC. If revoked any farther dental treatment will be suspended at CMDC.

I have read and understand the content of this document and understand a fax copy or photocopy shall be considered as valid as the original.

This authorization will expire (1) one year from this date_____

(circle relationship below and sign)
Signature of Patient/ Parent/ Guardian

_____

Print name if different from patient

_____

Witness_____ Title _____

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, 20 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) _____

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
309 Gravel Pike
Collegeville, Pennsylvania 19426
Voice: (610) 489-1313 Fax: (610) 489-5859

When we schedule appointments, we set aside time and professional resources to meet the individual needs of our patients, including time for a one-on-one consultation. When a patient fails to show up for an appointment, or to cancel within 24 hours of the appointment, our valuable resources are idle. More importantly, a patient care opportunity is missed.

We understand that there are occasions when a patient must miss an appointment due to unforeseen circumstances or a scheduling conflict beyond his or her control. In this event, we ask that you call our office and cancel your appointment within 24 hours of the scheduled visit. This courtesy allows my office staff to schedule another patient who is also in need of dental care.

Signature_____

Witness_____

Date_____