the dentist
on skillman

WELCOME TO OUR PRACTICE

We are thrilled and honored that you have chosen us to provide your dental care needs, and we look forward to meeting with you soon. Our team at The Dentist On Skillman consists of a handful of qualified professionals who work as a team to provide you the best quality dental care in a warm, family-friendly environment. Our patients are important to us and we will do everything possible to deserve your confidence and trust.

Your first visit will include a brief tour of our state-of-the-art office, a thorough review of your medical and dental history, a comprehensive oral examination, and a professional consultation. Dental radiographs will be taken as needed. We strive to make this initial visit as comfortable as possible, and we welcome you to take full advantage of the many amenities we offer for our patients.

Please complete the forms enclosed with this letter and bring them with you to your appointment. As a courtesy to you, we will contact your dental insurance carrier to determine an estimate of what they will contribute towards your dental care. We ask that you bring your insurance card along with a photo ID so we can start that process soon after your arrival.

We respect your time and offer convenient, automated email and/or text messages regarding appointment times. Please let us know which method of contact you would prefer, or if you would rather receive a phone call reminder instead.

Thank you once again for choosing The Dentist On Skillman!

Warm Regards,

Lawrence Wong, DMD
Practice Founder

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PATIENT REGISTRATION

PATIENT INFORMATION

PATIENT'S FIRST NAME	LAST NAME	PREFERS TO BE CALLED	TODAY'S DATE
STREET ADDRESS	CITY	STATE ZIP	DATE OF BIRTH
HOME PHONE	CELL PHONE	WORK PHONE	SOCIAL SECURITY NUMBER
EMAIL			PREFERED CONTACT METHOD

IF PATIENT IS A MINOR, PLEASE COMPLETE THIS AREA	PARENT/GUARDIAN NAME		RELATION TO PATIENT
	STREET ADDRESS (IF DIFFERENT)	CITY	STATE ZIP
HOME PHONE	CELL PHONE	WORK PHONE	SOCIAL SECURITY NUMBER
EMAIL			PREFERED CONTACT METHOD

EMERGENCY CONTACT INFORMATION

NAME	PHONE NUMBER	RELATIONSHIP

REFERRAL INFORMATION

WHOM MAY WE THANK FOR REFERRING YOU?	ARE THEY A PATIENT HERE? YES NO
OTHER SOURCE (CIRCLE ONE): INSURANCE COMPANY MAILING ONLINE SEARCH SOCIAL MEDIA NEWSPAPER/MAGAZINE DROVE BY	

DENTAL HISTORY

WHAT IS THE REASON FOR YOUR VISIT TODAY?		DATE AND REASON OF LAST DENTAL VISIT
PREVIOUS DENTIST NAME	CITY, STATE	HOW OFTEN DID YOU VISIT YOUR PREVIOUS DENTIST? EVERY 6 MONTHS ANNUALLY OCCASIONALLY
ARE YOU CURRENTLY HAVING ANY DENTAL PAIN OR DISCOMFORT?	ARE YOU AWARE OF ANY DENTAL PROBLEMS RIGHT NOW?	
ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR SMILE?	ARE YOU INTERESTED IN WHITENING?	
HAVE YOU EVER HAD ORTHODONTIC TREATMENT?	HAVE YOU EVER HAD A SERIOUS INJURY TO YOUR MOUTH OR HEAD?	
HAVE YOU EVER REQUIRED ANTIBIOTICS PRIOR TO DENTAL VISITS?	DO YOU HAVE ANXIETY ASSOCIATED WITH COMING TO THE DENTIST?	

MEDICAL HISTORY

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?	DATE OF MOST RECENT MEDICAL EXAM	
PHYSICIAN'S NAME	CITY, STATE	PHYSICIAN'S PHONE NUMBER
ARE YOU GENERALLY IN GOOD HEALTH?	**FOR WOMEN ONLY**	ARE YOU PREGNANT OR THINK YOU COULD BE PREGNANT? YES, ____ WEEKS NO

CONTINUED ON NEXT PAGE

MEDICAL CONDITIONS

DO YOU HAVE OR HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING MEDICAL CONDITIONS? (CIRCLE YES OR NO)			
ARTHRITIS YES NO	CHEST PAINS YES NO	HEART VALVE REPLACEMENT YES NO	OSTEOPOROSIS YES NO
ASTHMA YES NO	COPD (CHRONIC BRONCHITIS OR EMPHYSEMA) YES NO	HEPATITIS YES NO	SEIZURES YES NO
BLOOD OR BLEEDING DISORDERS YES NO	CONGENITAL HEART DEFECTS YES NO	HIV/AIDS YES NO	SICKLE CELL DISEASE YES NO
HIGH BLOOD PRESSURE YES NO	DIABETES YES NO	JOINT REPLACEMENT YES NO	SLEEP APNEA YES NO
LOW BLOOD PRESSURE YES NO	DRUG ADDICTION YES NO	KIDNEY DISEASE YES NO	STOMACH REFLUX OR ULCERS YES NO
CANCER OR TUMOR YES NO	FAINTING OR DIZZY SPELLS YES NO	NEUROLOGICAL DISORDER YES NO	THYROID YES NO
CARDIOVASCULAR DISEASE YES NO	HEART ATTACK OR STROKE YES NO	PACEMAKER YES NO	TUBERCULOSIS YES NO
LIST ANY OTHER CONDITIONS:			TOBACCO USE YES NO

MEDICATIONS

ARE YOU TAKING ANY PRESCRIPTION MEDICATIONS, OVER-THE-COUNTER MEDICATIONS, AND/OR DIETARY SUPPLEMENTS ON A REGULAR BASIS? YES NO
IF YES, PLEASE LIST ANY AND ALL MEDICATIONS:

ALLERGIES

ARE YOU ALLERGIC OR SENSITIVE TO LATEX PRODUCTS? YES NO	ARE YOU AWARE OF ANY ALLERGIES TO MEDICATIONS? YES NO
IF YES, PLEASE LIST THE MEDICATION(S) TO WHICH YOU ARE ALLERGIC:	

ACKNOWLEDGEMENT & CONSENT

Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. By signing below, I certify that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. Should additional information be needed, I grant permission to release pertinent health information from my other healthcare providers. I will notify this office of any changes in health or medication.

I give consent to have examination performed with or without appropriate radiographs and/or photographs in order for the Doctor to make a thorough diagnosis of my, or my dependent's, dental condition. I give consent to the use and disclosure of written and electronic health records that are individually identified as mine, or my dependent's, for the purpose of carrying out treatment, payment, and health care operations. I understand that only the minimal amount of information necessary will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

PATIENT SIGNATURE_____

PARENT/GUARDIAN SIGNATURE_____

(IF PATIENT IS A MINOR)

DATE_____

DENTIST REVIEW	DATE

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INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER

INSURANCE COMPANY NAME	EMPLOYER NAME
PRIMARY INSURED NAME	PRIMARY INSURED DATE OF BIRTH
PRIMARY INSURED SOCIAL SECURITY NUMBER	RELATION TO PATIENT
GROUP NUMBER	MEMBER ID NUMBER

SECONDARY INSURANCE CARRIER

INSURANCE COMPANY NAME	EMPLOYER NAME
PRIMARY INSURED NAME	PRIMARY INSURED DATE OF BIRTH
PRIMARY INSURED SOCIAL SECURITY NUMBER	RELATION TO PATIENT
GROUP NUMBER	MEMBER ID NUMBER

FINANCIAL RESPONSIBILITY

All professional services rendered are due at the time of service unless other arrangements have been made in advance with our office. Necessary forms will be completed to file for insurance carrier claims. I understand that I am responsible for any amount not covered by insurance.

INSURANCE POLICY

As a courtesy to our patients, we will submit insurance claims on your behalf. Please understand that all fees are estimated based on information provided by the insurance, and is not a guarantee of payment by them. In the event that the insurance company does not pay their estimated portion, the patient/responsible party will be responsible for that amount. Please note, the safety and care of our patients are our number one priority. Insurance can be a great asset and we will always do everything in our power to ensure you are rewarded every benefit allotted in your insurance contract. However, the treatment we recommend and the fees we charge will always be based on your individual needs, not your insurance coverage.

ASSIGNMENT OF BENEFITS

I authorize and direct payment of dental insurance benefits, otherwise payable to me for services rendered, directly to The Dentist On Skillman. In the event that the insurance company misdirects payment to me, I understand that I am responsible to remit such payments to The Dentist On Skillman.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of pertinent medical data to my insurance company about my diagnoses and/or treatments in order to submit all necessary insurance claims that may arise from the course of examination and/or treatment, and allow a photocopy of my signature to be used to process such claims for an indefinite period of time. This order will remain in effect until revoked by me in writing.

PATIENT SIGNATURE_____

PARENT/GUARDIAN SIGNATURE_____

(IF PATIENT IS A MINOR)

DATE_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICES DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCES TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR PROTECTED HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect April 1, 2016, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We use and disclose protected health information about you for treatment, payment, and healthcare operations. For example:
Treatment: We may use and disclose your protected health information to a dentist, hygienist or other healthcare provider for treatment purposes.
Payment: We may use and disclose your protected health information to bill for and collect payment for services we provide to you.
Healthcare Operations: We may use and disclose your protected health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare providers, evaluating provider performance, conducting training programs, peer review, accreditation, certification, licensing or credentialing activities.
Authorization: In addition to our use and disclosure of your protected health information for treatment, payment or healthcare operations, you may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. You may revoke such authorization at any time by written request, but we cannot take back any uses or disclosures already made with your permission. Unless you give us a written authorization, we cannot use or disclose your protected health information for any reason except those described in this Notice.
To Your Family and Friends: We may disclose protected health information about you to your family members or friends if we obtain your verbal authorization to do so or if we give you an opportunity to object and you do not object. We also may disclose protected health information to your family or friends if we can infer from the circumstances, based on our reasonable judgment, that you would not object, for example when you bring your spouse with you when treatment is discussed. We may use our professional judgment to infer that it is in your best interest to allow another person to pick-up filled prescriptions, medical supplies, x-rays or recommend that they take you to your physician or emergency room. We may use or disclose protected health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, or your general condition. If you are present, then prior to use or disclosure of your protected health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose protected health information based on a determination using our professional judgment, disclosing only protected health information that is directly relevant to the person's involvement in your healthcare.

Marketing Health-Related Services: We may use or disclose your protected health information for marketing purposes with your written authorization.

Required by Law: We may use or disclose your protected health information when we are required to do so by federal, state or local law or legal process, for example, subpoena, court order, administrative order, warrant, or summons; and pursuant to workers' compensation laws.

Abuse or Neglect: We may disclose your protected health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your protected health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Governmental Officials and Law Enforcement: We may disclose to authorized governmental officials protected health information required for lawful investigation, military authorities, the protected health information of Armed Forces personnel, and a correctional institution or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as postcards, voicemail message, or letters) or information about oral health care, and related benefits and services.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies, postage and staff time. If you request an alternative format that we can practicably provide, we will charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request in writing that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). We are required to agree to requests that we not disclose protected health information to your health plan with respect to services for which you have paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your protected health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Breach Notification: You have the right to receive notice if the security of your unsecured protected health information is breached.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive a paper copy of this Notice upon request.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made to amend or restrict the use or disclosure of your protected health information or to have us communicate with you by alternative means or at alternative locations, you may submit a complaint to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your protected health information. You will not be penalized in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

[You may refuse to sign this Acknowledgement]

I have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

[For Office Use Only]

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please specify) _____

_____

_____