PATIENT INFORMATION

Name _____ ☐Married ☐Single ☐Minor ☐Male ☐Female
Last First MI

Social Security #_____ Today's Date_____

Address _____
Street City State Zip Code

Birthdate_____ E-mail_____

Telephone (home)_____ (cell)_____
(work)_____ (other)_____

Have you seen us on: *(check all that apply)* ☐ Facebook ☐ Twitter ☐ Google Reviews
☐ Billboard ☐ Local Magazine / Newspaper

Employer name and address_____
Person to contact in case of emergency: Name_____ Phone_____

How did you find us? ☐ referred by a friend: _____ ☐ other: _____
May we contact this person to thank them for your referral? **YES** **NO**

Dental Insurance Information

PRIMARY INSURED

_____ _____
Last name First name MI *Social Security number*

_____ _____
Date of Birth (Month/Day/Year) *Relationship to patient (self, father, mother, spouse, guardian)*

_____ _____
Employer of primary insured *Dental Insurance Company Name*

_____ _____
Subscriber # *Group #*

SECONDARY INSURED

_____ _____
Last name First name MI *Social Security number of secondary insured*

_____ _____
Date of Birth (Month/Day/Year) *Relationship to patient (self, father, mother, spouse, guardian)*

_____ _____
Employer of secondary insured *Dental Insurance Company Name*

_____ _____
Subscriber # *Group #*

I hereby authorize payment directly to Dr. Rita Tempel's office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment whether covered by the insurance plan or not. I authorize Dr. Tempel to administer medication and perform diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information listed above is correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

_____ _____
Patient or responsible party signature *Date*

Dr. Rita A. Tempel and Associates
2018 York Road
Gettysburg, PA 17325-8207

(717)339-0033
info@gettysburgsmiles.com
www.gettysburgsmiles.com

Medical History Form

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Name and Phone Number of Physician?

Date of Last Physical Examination?

Have you ever been hospitalized?

◯ Yes ◯ No

If yes, please explain.

What medications are you currently taking?- including over the counter, vitamins, supplements and oral contraceptives.

Are you allergic to any of the following:

☐ Amoxicillin ☐ Aspirin ☐ Codeine ☐ Latex ☐ Metal
☐ Penicillin ☐ Sulfa

Other known allergies including food allergies

Dr. Rita A. Tempel and Associates
2018 York Road
Gettysburg, PA 17325-8207

(717)339-0033
info@gettysburgsmiles.com
www.gettysburgsmiles.com

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

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other	☐ Adhesive allergy
☐ Alcoholism	☐ Allergies	☐ Allergy - Aspirin	☐ Allergy - Codeine
☐ Allergy - Erythro	☐ Allergy - Latex	☐ Allergy - Other	☐ Allergy - Penicillin
☐ Allergy - Sulfa	☐ Allergy-Amoxcillin	☐ Anemia	☐ Angina
☐ Arthritis	☐ Artificial Joints	☐ Aspirin Therapy	☐ Asthma
☐ Autoimmune Disorder	☐ Bisphosphonates hx	☐ Bleeding Disorder	☐ Cancer
☐ Diabetes	☐ Epilepsy	☐ Fainting	☐ GERD/Acid Reflux
☐ Glaucoma	☐ Head Injuries	☐ Heart Attack	☐ Heart Disease
☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure	☐ HIV
☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorders	☐ Metal Allergy
☐ Nervous/Anxiety	☐ No Epi	☐ Oral Infection	☐ Osteoporosis
☐ Other_____	☐ Pacemaker	☐ Plavix/Coumadin	☐ Pregnancy
☐ Radiation/Chemo	☐ Recreation Drugs	☐ Red Dye Allergy	☐ Rheumatic Fever
☐ Rheumatism	☐ Sinus Problems	☐ Sleep Apnea	☐ Smoking/Tobacco
☐ Stroke	☐ Thyroid Disease	☐ Tuberculosis	☐ Tumors / Growths
☐ Vertigo/Dizziness			

WOMEN: Is there a possibility that you are pregnant?

◯ Yes ◯ No

Additional Notes:

To the best of my knowledge, all preceding answers are correct. If I have any changes in my health status, I shall inform the dentist and/or the staff at the next dental appointment.

Signature: _____ Date: _____

Dental History Form

Patient Name: _____ **Date**: _____

1. Date of last dental visit:_____
2. How often were you seen for your cleanings? _____
3. Do you have any dental pain or concerns at the present time? **Yes or No**

   If so, where? _____ For how long? _____
4. Do you have any jaw / joint pain? **Yes or No**
5. Are you aware if you clench or grind? **Yes or No** Do you have a night guard? **Yes or No**

   Do you have any other oral habits (circle): **nail biting ice chewing other: _____**
6. Do you smoke? **Yes or No** / Chew tobacco? **Yes or No**

   How often? _____ For how long? _____
7. How often do you brush your teeth? _____ What toothpaste do you use? _____
8. Do you use mouth rinse? **Yes or No** / Which mouth rinse do you use? _____
9. How often do you floss your teeth? (circle answer) **daily occasionally never**
10. Do you have any history of the following? (circle): **Tongue/lip piercings**

    Face/jaw trauma Orthodontic work Dental implants Periodontal surgery
11. Do you suffer from dental anxiety? **Yes or No**

    Would you be interested in nitrous oxide (laughing gas): **Yes or No**
12. Do you like your smile? **Yes or No**
13. Is there anything you would like to change about your smile? (circle)

    Whiter teeth or Straighter teeth
14. What are your dental goals? (please circle one or more)

    A. Full mouth treatment / "Smile Makeover" **B. Remove all silver fillings**
    C. Treatment as needed only **D. Other_____**

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my dental health, I shall inform the dentist and staff at my next appointment.

Patient or Guardian Signature: _____ Date: _____

Reviewed by Doctor: _____ Date: _____

Office Financial Policy

Thank you for choosing us for your dental treatment. Please read our office financial policy, then sign and date the bottom of the page as confirmation of your understanding of our policy.

For patients with dental insurance coverage, the following information applies:

As a courtesy to you, we will submit a claim to your primary insurance company once you have supplied us with all of your insurance information. Please be aware that your dental insurance policy is a contract between you, your insurance company and possibly your employer. We are not a party to that contract and cannot accept the responsibility of your claim. It is your responsibility to know your dental insurance coverage.

We will collect your deductible and your estimated copay at your treatment appointment._____
initials

Your particular plan may not cover some of the dental services necessary for your treatment. Since most insurance policies do not cover services 100%, a portion, and perhaps all of your charges may be payable at the time of service. Reduction or rejection of a claim by your insurance company does not relieve the financial obligation you have incurred. We are happy to submit your claim with copies of your x-rays and treatment notes at no cost to you. However, we are unable to negotiate any unpaid claims. Payment by your insurance company should be received within 30 days of your dental visit. At that time the balance of your account will become due. We will bill you your balance once we receive payment on a claim. For accounts past 60 days, there will be a finance charge of 1.5%. The accounts which remain unpaid over 90 days will be considered delinquent and may be turned over to our collection agency.

If your dental insurance plan does not accept assignment of benefits, then full payment is due when services are rendered. We will submit your dental claim on your behalf, and your insurance company will send payment on your claim directly to you.(Examples of these dental insurance plans are Delta Dental of PA and United Concordia.)

With the help of the internet, we are able to access your dental plan coverage benefits, limitations, and eligibility requirements. We encourage you to visit your dental insurance company website and learn all that you can about your coverage.

For patients with no dental insurance coverage, payment is due when services are rendered.

Cancellation and Returned Checks Policy A 48 hour notice is requested when cancelling and/or rescheduling appointments. If an appointment is not kept or cancelled in less than 48 hours, we may charge a cancellation fee of $50.00/ hour. Returned checks will incur a $40.00 processing fee. _____
initials

I have read and understand the above financial policy and accept responsibility for payment of services rendered. I understand that I am responsible for any amount not covered by my insurance. If any legal action is required to collect any unpaid balances, I agree to absorb the cost of all such expenses (collection agency fees, attorney fees, etc.).
**Please note, the parent or guardian who signs this agreement will be responsible for the account.*

_____ _____
Signature of Patient or Guarantor *Date*

HIPAA Consent and Release

Acknowledgement of Receipt of Notice of Privacy Practices

The HIPAA Rule for Privacy establishes standards that address the use and disclosure of an individual's health information, referred to as "protected health information," that is created, stored and exchanged by Covered Entities (Covered Entities include health care providers, health plans, and health care clearinghouses), and to provide a standard for health care providers to carry out treatment, payment and health care operations.

As our patient, it is important that you know we respect the privacy of your personal dental records, and we strive to secure, protect, and take reasonable precautions to protect your privacy. When it is appropriate and necessary we provide the minimum required information to only those we feel are in need of your health care information. We may also provide information about your treatment, payment or health care operations, in order to provide health care that is in your best interest. We may have indirect treatment relationships involved in your care (such as laboratories that only interact with doctors and not patients), and we may have to disclose personal health information for purposes of treatment, payment, or health care operations. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing to our office. Under the privacy law, we have the right to refuse to treat you should you choose to refuse to disclose your personal health information. If you agree to the consent and release of this document, at some future time you may request or refuse all or part of your personal health information. You may not, however, revoke actions that have already been taken which relied on this or a previously signed consent.

You have the right to review our Notice of Privacy Practices before you decide whether to sign this consent and release form. This Notice includes important matters about your protected health information. We reserve the right to change our privacy practices as described in this Notice. If a changed occurs, we will issue a revised Notice of Privacy Practices containing any amendments, which may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions, at anytime by contacting our office with the request.

Release of Information

In addition to the necessary release of information as stated above, I authorize the release of information including diagnoses, records (written and images), financial status, and appointment information to:

- ○ _____Relationship_____
- ○ _____ Relationship_____
- ○ _____Relationship_____
- ○ Not Applicable

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

Signature: _____ Date: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____