

Welcome

**Thank you for selecting our dental health team.
We look forward to working with you in maintaining your dental health.**

Date ____/____/____

Name _____
Last First M.I.

Address _____

City _____ State _____ Zip Code _____

Home Phone (____) _____ Work Phone (____) _____

Cell Phone (____) _____ Pager Phone (____) _____

Email address _____

Date of Birth ____/____/____ Social Security # ____ - ____ - ____

Single Married Divorced Widowed

Name of Your Employer _____

Person to Contact in Case of an Emergency _____

Their Home Phone (____) _____ Work Phone (____) _____

***Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION

(If you are the subscriber of the account, only fill out the first two questions.)

Name of Insurance _____

Group Number _____

Name of Subscriber _____

Name of Employer _____

Is this form for Spouse Child

Subscriber's Social Security # ____ - ____ - ____

Subscriber's Date of Birth ____/____/____

Do you have secondary insurance? Yes No

Name of Insurance _____

Group Number _____

Subscriber's Social Security # ____ - ____ - ____

Name of Employer _____

YOUR MEDICAL HISTORY

1. Are you in good health? Yes No If no, please explain _____
2. Are you under a physician's care now? Yes No If yes, please give reason for treatment _____
3. Name of Your Physician _____ Address _____
4. Has there been any recent change in your general health? Yes No If yes, please explain _____
5. Date of Your Last Physical Examination ____/____/____
6. Are you taking any medications at this time? Yes No If yes, please list _____
7. Please check any illnesses you have had or presently have:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Valve (leaking or defective)
<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> HIV Positive	<input type="checkbox"/> AIDS	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Pace Maker	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Lung Conditions	<input type="checkbox"/> Joint Replacement
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Kidney/Liver Problem
8. Do you have any condition not listed above that you think we should know about? Yes No If yes, please explain _____
9. Do you have any trouble with prolonged bleeding? _____
10. Have you ever had any unusual reaction to an anesthetic or drug (like penicillin)? Yes No If yes, please explain _____
11. Do any family members have diabetes? Yes No
12. Do you smoke? Yes No If yes, how much _____
13. Do you use smokeless tobacco? Yes No If yes, how much and how long _____
14. What is the name of your water company? _____

YOUR DENTAL HEALTH

1. When was your last dental visit? _____
2. Name of your previous dentist? _____ Address _____
3. Does your child take fluoride at home? Yes No
4. What is your dental preference?

<input type="checkbox"/> local anesthetic (Novocaine)	<input type="checkbox"/> no anesthetic	<input type="checkbox"/> relative analgesia (Nitrous Oxide)
<input type="checkbox"/> oral pre-medication	<input type="checkbox"/> I.V. Sedation	
5. Have you ever had any unfavorable reaction from previous medical or dental care? Yes No If yes, please explain _____
6. Have you ever had periodontal disease? Yes No
7. Are you pleased with the appearance of your teeth? Yes No If no, why? _____
8. Are you in pain now? Yes No If yes, where? _____
9. Do your gums bleed? Yes No If yes, please explain _____
10. Do your teeth feel loose? Yes No If yes, please explain _____
11. Do you grind or clench your teeth during the day or night? Yes No
12. Do you have sore or sensitive teeth? Yes No If so, is it to: sweets hot cold
13. Do you have pain elsewhere in your face or jaws? Yes No If yes, where? _____
14. Does food collect between your teeth? Yes No
15. Do you think you have bad breath? Yes No

I, the undersigned, do affirm that the above information is correct and do give consent to agreed upon dental service, and use of appropriate methods thereto.

Signed _____ Date ____/____/____
 Patient or Guardian

Date: ____ / ____ / ____

Patient: _____

Parent or Guardian: _____

Address: _____ Phone: (____) _____

I hereby agree to pay Dr. Warren D. Silvers, D.M.D. for professional services rendered. I understand that I am responsible for the entire amount due, payable at the time of services unless prior financial arrangements have been made.

If there is dental insurance, then services will be billed to the carrier as a courtesy and all monies received will be credited to my account. I am responsible for any charges, processing delays or other circumstances. All unpaid charges will be reflected on a monthly statement. We reserve the right to attach finance charges on any balance over 30 days old.

I understand that when appropriate, credit bureau reports may be obtained. I am responsible for co-payment and /or deductibles at the time of service.

Signature of person responsible for account: _____

Date: ____ / ____ / ____

INSURANCE SIGNATURE ON FILE
(Sign only if you have insurance)

The benefits payable under the below named insurance policy have been assigned to:
Warren D. Silvers, D.M.D., 4392 Sturbridge Drive, Harrisburg, PA 17110.

AUTHORIZATION TO PAY BENEFITS DIRECTLY TO DENTIST:

I hereby authorize payment directly to Warren D. Silvers, D.M.D. for all dental benefits entitled to me for dental treatment. I understand that I am financially responsible for all charges not covered by this assignment for any reason.

Insurance Company's Name: _____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Dr. Silvers to release any information acquired in the course of my examination or treatment to the above named insurance company, or to any dentist to whom I am referred.

Signed _____ Date ____ / ____ / ____

Silvers Family Dental Care

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

By signing this form you are stating that you have received a copy of this office's Notice of Privacy Practices.

Patient Name

Patient/Guardian Signature

Date

For Office Use Only

We attempt 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 acknowledgement
- Other (Please specify) _____

Silvers Family Dental Care

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose 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, your general condition, or death. If you are present, then prior to use or disclosure of your 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 health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communication without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your 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 health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge \$2.00 for each page, \$25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 months, but not before April 14, 2003. 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 that we place additional restrictions on our use or disclosure of your 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).

Alternative Communication: You have the right to request that we communicate with you about your 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 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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect 04/01/2003, 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 health information that we maintain, including 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.

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 health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain 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 health information. We will not retaliate in any way if choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Tracy Rishell

Telephone: (717) 564-1681

Fax: (717) 214-3302

Address: 4392 Sturbridge Drive
Suite 100
Harrisburg, PA 17110