KEYSTONE PERIODONTAL GROUP

27 Village Center Dr
Reading, PA 19607
610- 777-7002

PATIENT INFORMATION

Patient's Full Name: _____

Patient's Preferred Name (Nickname): _____ Today's Date: _____

Date of Birth: _____ SSN: _____ Gender: ⬜ M ⬜ F

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Preferred Contact Method: ⬜ Home Phone ⬜ Cell Phone ⬜ Email ⬜ Other:_____

Occupation: _____

Employer Name: _____ Work Phone: _____

Marital Status: ⬜ Single ⬜ Married ⬜ Other:_____

EMERGENCY CONTACT

In case of emergency, who should we contact: _____

Relationship to patient: _____ Phone number: _____

DENTAL INFORMATION

Referring Dentist: _____ General Dentist (if different): _____

Main reason for today's visit: _____

_____

How often do you normally get cleanings? _____ When was your last cleaning? _____

Have you ever had periodontal treatment before? ⬜ Y ⬜ N If so, when? _____

Are your teeth sensitive to: ⬜ Cold ⬜ Hot ⬜ Sweet ⬜ Eating ⬜ Other: _____

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MEDICAL INFORMATION

Patient Name: _____ DOB: _____ Age: _____

Primary Care Physician: _____ Phone: _____

Do you see any other specialists? Please list doctor and specialty: _____

_____

Have you been hospitalized/had a major operation in the past 5 years? ⬜ Yes ⬜ No

If yes, what for? _____

Do you have any allergies to any medication? ⬜ Yes ⬜ No

If yes, which? _____

Do you use Cigarettes/Tobacco? ⬜ Yes ⬜ No ⬜ Previously ⬜ Vape ⬜ Marijuana ⬜ Other: _____

Do you routinely take antibiotics before dental procedures? ⬜ Yes ⬜ No

If yes, what type and what for? _____

Have you ever taken **Bisphosphonates**? (ie: Fosamax, Actonel, Boniva, Zometa, Reclast, Aredia) ⬜ Yes ⬜ No

If yes, when did you start the medication? _____

Do you take any blood thinning medications? (ie: Warfarin, Xarelto, Eliquis, Pradaxa, etc) ⬜ Yes ⬜ No

Please indicate if you have/had any of the following conditions:

⬜ Heart Attack	⬜ Liver Disease	⬜ Substance Abuse
⬜ Stroke	⬜ Kidney Disease	⬜ Osteoporosis
⬜ Artificial Heart Valve	⬜ Asthma	⬜ Arthritis
⬜ High Blood Pressure	⬜ Epilepsy or Seizures	⬜ Joint Replacement
⬜ Pacemaker	⬜ HIV/AIDS	⬜ Anxiety
⬜ Bleeding Disorder	⬜ Hepatitis A, B, or C	⬜ Depression
⬜ Diabetes	⬜ Cancer treatment	⬜ Pregnant/Nursing (currently)

Please list any other medical condition, disease or problem that you have that is not listed above: _____

_____

Please list **all** medications you are currently taking: _____

_____

_____

To the best of my knowledge, all preceding information is correct and true. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in medical status.

Signature: _____ Date: _____

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HIPAA Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician,our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred or who referred you to us, to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health Issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164 500.

Other Permitted and Required Uses and Disclosures Will be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing,except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted.You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment,you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made,if any,of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and became effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

PRINT NAME_____

SIGNATURE_____ DATE _____

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Authorization

I hereby authorize the diagnosis of my dental health by means of clinical exam, radiographs, study models, photographs, and/or other diagnostic aids deemed appropriate.

Signature: _____ Date: _____

Permission to Discuss Dental Information

The privacy of your dental and medical information is very important to us. If you wish to discuss dental/medical information to your family, friends, or others, please indicate this by completing the information below:

I, _____, hereby authorize the use or disclosure of my protected health information as described below. Staff and/or doctors at Keystone Periodontal Group, LLC are hereby authorized to discuss protected health information to : _____ (relationship) _____.

The health information that may be disclosed:

- ⬜ Limited to: _____
- ⬜ All past, present and future healthcare information

I understand that the information used or disclosed under this authorization form may be subject to redisclosure by the person(s) or facility(ies) receiving it and would then no longer be protected by federal privacy regulations. I have the right to refuse to sign his authorization form. If signed, I have the right to revoke this authorization form, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions.

Signature: _____ Date: _____

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INSURANCE INFORMATION

We DO NOT participate with any dental insurance. The patient is responsible for our fees at the time of service.

As a courtesy, we will submit claims to your insurance. **What is or is not covered by your insurance is a contract between the insurance company and the subscriber**. **IF** the service is covered by the insurance contract, they will reimburse the patient directly. In the event your insurance sends the reimbursement check to our office, we will issue the responsible party on the account a refund. We do not bill Medicare/Medicaid and/or medical insurances.

I understand that I am financially responsible for any treatment rendered at the time of service.

Signature: _____ Date: _____

Do you have dental insurance? ⬜ Yes ⬜ No

PRIMARY DENTAL INSURANCE: _____

Subscriber Name: _____ Date of Birth: _____

Phone Number: _____ Relationship to Patient: _____

Subscriber ID #_____ Group # _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

SECONDARY DENTAL INSURANCE: _____

Subscriber Name: _____ Date of Birth: _____

Phone Number: _____ Relationship to Patient: _____

Subscriber ID #_____ Group # _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____