BUCKS DENTAL associates

Cosmetic, Implant and Family Dentistry

Patient Information
(All information below is required and confidential)

Patient Name:_____ Date:_____
Last First Mi

❑ Male ❑ Female ❑ Married ❑ Single ❑ Child ❑ Other_____

Social Security #:_____ Birth Date:_____ Driver's License #:_____

Phone (H): ( )_____ W: ( )_____ Ext:_____

E-Mail Address:_____ Pager:_____

Address:_____
Street Apartment #

_____
City State Zip

If Student, Name of School/College: _____
❑ Full ❑ Part-time School City State

Spouse or Responsible Party Information

Name of Person Responsible for this account:_____ Relationship to Patient:_____

Address:_____
Street Apartment #

_____
City State Zip

Social Security #:_____ Birth Date:_____ Driver's License #:_____

Phone (H): ( )_____ W: ( )_____ Ext:_____

E-Mail Address:_____ Pager:_____

Employment Information

The following is for: ❑ the patient ❑ the person responsible for payment

Employer Name:_____ Occupation:_____

_____
Street City State Zip

Referral Information

Whom may we thank for referring you to our practice?

❑ Another patient, friend ❑ Another patient, relative ❑ Dental office ❑ Yellow pages

❑ Newspaper ❑ School ❑ Work ❑ Other_____

Name of person or office referring you to our practice:_____

Patient Dental History

Date of last dental appointment_____ **Reason for today's visit?** _____
How often do you brush your teeth? _____ **How often do you floss?** _____

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold foods/liquids?	☐	☐
3. Are your teeth sensitive to sweet or sour foods/liquids?	☐	☐
4. Are any particular teeth causing you discomfort?	☐	☐
5. Do you have any sores/lumps in or near your mouth?	☐	☐
6. Have you ever had any head, neck or jaw injuries?	☐	☐
7. Do you clench or grind your teeth?	☐	☐
8. Do you bite your lips or cheeks frequently?	☐	☐
9. Have you ever had any difficult extractions in the past?	☐	☐
10. Have you ever had prolonged bleeding associated with any dental treatment?	☐	☐

How would you rate your smile on a scale of 1-10? (10 being the best) 1 2 3 4 5 6 7 8 9 10

Patient Medical History

Physician _____ **Office Phone** _____ **Date of Last Exam** _____

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you been hospitalized for any surgical operation or serious illness?	☐	☐
3. Do you take aspirin regularly?	☐	☐
4. Do you use tobacco products?	☐	☐
5. Do you use controlled substances?	☐	☐
6. Do you wear contact lenses?	☐	☐
7. Do you wear a hearing aid?	☐	☐
8. Women only:		
(a) Are you or think you might be pregnant?	☐	☐
(b) Are you nursing?	☐	☐
(c) Are you taking oral contraceptives?	☐	☐
(d) Do you have any problems associated with your menstrual period?	☐	☐

	YES	NO
9. Are you allergic or have you reacted adversely to any of the following:		
Local Anesthetics (e.g. Novocain)?	☐	☐
Penicillin or other antibiotics?	☐	☐
Sulfa Drugs?	☐	☐
Barbiturates?	☐	☐
Sedatives?	☐	☐
Iodine?	☐	☐
Aspirin?	☐	☐
Any metals (Nickel, Mercury, etc.)?	☐	☐
Latex?	☐	☐
10. Are you taking any medication(s) including non-prescription medicine?	☐	☐

If so, what medications are you taking? Dosage

_____ _____
_____ _____
_____ _____

- ☐ Acid Reflex (heartburn)
- ☐ Artificial joints
- ☐ Blood Disease
- ☐ Circulatory Problems
- ☐ Fainting
- ☐ Heart Murmur
- ☐ Jaw Pain
- ☐ Neck Pain
- ☐ Pacemaker
- ☐ Respiratory Problems
- ☐ Shortness of Breath
- ☐ STD's (Venereal Diseases)
- ☐ Thyroid Problems
- ☐ AIDS or HIV infection
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Joint Replacement
- ☐ Nervous Disorders
- ☐ Panic Attacks
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Tobacco Use
- ☐ Allergies
- ☐ Asthma
- ☐ Chemical Dependency
- ☐ Dizziness
- ☐ Hay Fever
- ☐ High/low Blood Pressure
- ☐ Kidney Disease
- ☐ Pregnancy--Due date_____
- ☐ Psychiatric Care
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Back Problems
- ☐ Eating Disorder
- ☐ Headaches
- ☐ Liver Disease
- ☐ Radiation Treatment
- ☐ Shoulder Pain
- ☐ Snoring
- ☐ Swelling of feet or ankles
- ☐ Tumors
- ☐ Anxiety
- ☐ Bleeding Disorder
- ☐ Chemotheraphy
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Angina Pectoris
- ☐ By-Pass Surgery
- ☐ Congenital Heart failure/lesion
- ☐ MI
- ☐ Valve Replacemt
- ☐ Ulcers

TMJ/MFP History

- ☐ Back Pain
- ☐ Dizziness
- ☐ Ear Congestion
- ☐ Ear Pain
- ☐ Eye Pain
- ☐ Facial Pain
- ☐ Fatigue
- ☐ Headaches
- ☐ Jaw Clicking
- ☐ Jaw Joint Noises
- ☐ Jaw Locking
- ☐ Limited Mouth Opening
- ☐ Muscle Soreness
- ☐ Muscle Twitching
- ☐ Pain when chewing
- ☐ Ringing in the ears
- ☐ Shoulder Pain
- ☐ Sinus Congestion
- ☐ Throat Pain
- ☐ Tinnitis
- ☐ Visual Disturbances

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I also agree to allow release of my treatment/x-rays for the purpose of collecting reimbursement from my insurance carrier.

(Sign Here)

_____ _____
Signature date

Reviewed by Date Comments

_____/_____/_____
_____/_____/_____

BUCKS DENTAL associates

Cosmetic, Implant and Family Dentistry

DENTAL INSURANCE INFORMATION

PRIMARY

Name of insured:_____ Is Insured a patient ( ) Yes ( ) No
Last First M

Insured's Address:_____ ID#:_____ Group:_____

Insured's Employer Name:_____

Address_____
Street City State Zip

Patients relationship to insured: ( ) Self ( ) Spouse ( ) Child ( ) other _____

Insurance plan name and phone #:_____

MEDICAL INSURANCE INFORMATION

Name of insured:_____ Is Insured a patient ( ) Yes ( ) No
Last First M

Insured's Address:_____ ID#:_____ Group:_____

Insured's Employer Name:_____

Address_____
Street City State Zip

Patients relationship to insured: ( ) Self ( ) Spouse ( ) Child ( ) other _____

Insurance plan name and phone #:_____

Insurance is primarily based on "eligibility" not "medical necessity"
Our treatment plans are base solely on medical necessity.

BUCKS DENTAL associates

Cosmetic, Implant and Family Dentistry

FINANCIAL POLICY

In developing treatment plans for our patients we are guided by the current standard of care within the dental profession and by our own high standard of ethics and moral responsibility to our patients. Our responsibility is to provide you with the highest quality of care, using the latest concepts and techniques in a clean and safe environment. In order to achieve this goal we need your assistance and complete understanding of our financial policy. You are ultimately responsible for the fees for the professional services provided.

Payment for services is due at the time services are rendered. For your convenience we accept cash and all major credit cards. In cases of comprehensive treatment plans that extend over time (such as periodontal, prosthodontic, or extensive treatments) a special payment schedule may be arranged in advance. This will require a minimum deposit of 50% of the total estimated patient portion of the fees at the start of treatment.

For those patients enrolled in a dental assistance plan (commonly referred to as dental insurance) we will be happy to assist you in processing your forms for your reimbursement. In many cases after your insurance company has verified your eligibility and notified us of assignment of benefits, you will have to pay only your deductible and/or co-pay at each visit. We will wait up to 30 days for your dental insurance to pay the balance. **However, if payment is not received within 30 days then the entire amount becomes due and payable by you immediately.**

The adult parent or guardian who accompanies a minor is responsible for full payment at the time of service.

Missed Appointment: When we schedule your appointment, the time is reserved exclusively for you. When you fail to notify us of your inability to keep an appointment, another patient in need of dentistry is unable to receive treatment. We request that you give us at least 24 hours notice when you realize that you cannot keep an appointment. If you confirm your appointment and are a “NO SHOW”, a $75.00 fee will be access to your account. Multiple missed appointments may lead to dismissal from the practice.

Accounts unpaid after 30 days from the date of service incur a finance charge of 1.0% (6% annum) on the outstanding balance (or a minimum monthly charge of $5.00).

If your account is referred for collection you will be responsible for collection costs in the amount of 50% depending on the age of the outstanding balance and/or all court costs and reasonable attorney’s fees.

We will be happy to discuss your proposed treatment, fees for treatment, and answer any questions relating to your treatment or the professional fees. Please do not hesitate to ask for clarification on any matter concerning your treatment.

For individuals with **dental insurance**, please remember the following:

(1). **Your insurance is a contract between you, your employer, and the insurance company.** We are NOT a party to that contract and there is nothing we can do regarding the coverage provided; as dental care providers our relationship is with you not your insurance company.
(2). Our fees fall within the range authorized by many companies and most of our patients receive maximum assistance from their companies up to the policy limits; however, all patients are responsible for the policy deductibles and co-pays.
(3). A few companies reimburse on an arbitrary “fee schedule” which bears no relationship to the current standard of care or the actual cost providing services; not all services are a covered benefit in all contracts and some companies arbitrarily select certain services which they exclude.

If you need to finance your dental treatment, we offer Care Credit. Please ask our office manager for details.

We realize that temporary financial problems may affect the timely payment of you account. If such problems do arise please contact us promptly for assistance in the management of your account.

If you have any questions about your diagnosis, treatment plan, or any uncertainty regarding the professional fees or your dental insurance plan, please do not hesitate to ask us. We are here to serve you.

I have read and understood the Financial Policy and agree to abide by it.

Patient:_____ 

Date:_____

Additional family members include:
_____

_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Bucks Dental Associates
Kiran Satashia, D.M.D.
4 Meadowbrook Lane
Chalfont, PA 18917
P: 215-997-5550 F: 215-997-3375

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996(HIPAA). I understand that this information can and will be used to:

- **Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payers for my health care services.**
- **Conduct normal health care operations such as quality assessment and improvement activities.**

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has that right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________ Date: ______________

Signature: _________________________________

Relationship to Patient: ______________________

I here, by grant permission to allow Dr. Satashia and staff to discuss my treatment with:

***my wife *my husband *my mother *my father *my guardian**

***my child____________________ *other_________________ *Do not discuss**

Emergency Contact: ___________________________ Phone: ___________________________
(This person would be contacted only in the event of an emergency based on the doctor's discretion)

We now have the ability to e-mail and text you reminders of your scheduled and needed appointments. Please consent below to this correspondence and include your email and mobile number.

E-mail:__________________________ Mobile #:____________________________ Initial: ________

- -

For office Use Only:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

____ The patient refused to sign **____ Communication barriers**
____ Emergency situation **____ Other**

NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other providers or specialists involved in the continuation of your care.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we disclose treatment information when billing a dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. 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 certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health 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.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access inspect and copy your protected health information.
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of 27 June 2011 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 of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Privacy Officer/Jay Rana
Bucks Dental Associates
4 Meadowbrook Lane
Chalfont, PA 18914
215-997-5550

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

Please keep this copy for your records.

BUCKS DENTAL associates

Cosmetic, Implant and Family Dentistry

4 Meadowbrook Lane
Chalfont, PA 18914
P: 215-997-5550 – F: 215-997-3375

Date: _____

To: _____

_____

_____

Telephone:_____

Dear Dr. _____,

Please transfer my dental records, including all radiographs and other diagnostic records to Bucks Dental Associates or e-mail them to office@bucksmontdental.com

Thank you,

Sincerely,

_____
Patient's Signature

_____
Print Name

Names of other family included in this request:

1. _____

2. _____

3. _____