CIROCCO DENTAL CENTER

5280 PA Route 309
Center Valley • PA •18034

(610) 282-1278

Medical History Form

Patient Name: _____

Date of Birth: _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY YOU WILL RECEIVE. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

		IF YES, PLEASE EXPLAIN:
Are you under a physician's care now?	☐ Yes ☐ No	_____
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	_____
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	_____
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No	_____
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates?	☐ Yes ☐ No	
Are you on a special diet?	☐ Yes ☐ No	_____
Do you use tobacco?	☐ Yes ☐ No	_____
Do you use controlled substances?	☐ Yes ☐ No	_____

WOMEN: ARE YOU... ☐ Pregnant/Trying to Conceive ☐ Nursing ☐ Taking Oral Contraceptives ☐ None

Allergies: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics
☐ Other _____

Do you have, or have you had, any of the following? (PLEASE CIRCLE)

AIDS/HIV Positive	Chest Pains	Frequent Headaches	Hypoglycemia	Rheumatism
Alzheimer's Disease	Cold Sores/Fever Blisters	Genital Herpes	Irregular Heartbeat	Scarlet Fever
Anaphylaxis	Congenital Heart Disorder	Glaucoma	Kidney Problems	Shingles
Anemia	Convulsion	Hay Fever	Leukemia	Sickle Cell Disease
Angina	Cortisone Medicine	Heart Attack/Failure	Liver Disease	Sinus Trouble
Arthritis/Gout	Diabetes	Heart Murmur	Low Blood Pressure	Spina Bifida
Artificial Heart Value	Drug Addiction	Heart Pacemaker	Lung Disease	Stomach/Intestinal Disease
Artificial Joint	Easily Winded	Heart Trouble/Disease	Mitral Valve Prolapse	Stroke
Asthma	Emphysema	Hemophilia	Osteoporosis	Swelling of Limbs
Blood Disease	Epilepsy or Seizures	Hepatitis A	Pain in Jaw Joints	Thyroid Disease
Blood Transfusion	Excessive Bleeding	Hepatitis B or C	Parathyroid Disease	Tonsillitis
Breath Problems	Excessive Thirst	Herpes	Psychiatric Care	Tuberculosis
Bruise Easily	Fainting Spells/Dizziness	High Blood Pressure	Radiation Treatments	Tumors or Growths
Cancer	Frequent Cough	High Cholesterol	Recent Weight Loss	Ulcers
Chemotherapy	Frequent Diarrhea	Hives or Hash	Renal Dialysis	Venereal Disease
			Rheumatic Fever	Yellow - Jaundice

Have you ever had any serious illness not listed above? _____

Additional Comments: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian _____ Date _____

CIROCCO DENTAL CENTER

5280 PA Route 309
Center Valley • PA •18034

(610) 282-1278

Emergency Contact & Authorization For Release Of Health Information

Patient Name: _____

Date of Birth: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Address:: _____

Phone Number: _____

AUTHROIZATION FOR RELEASE OF HEALTH INFORMATION

Many of our patients allow family members such as their spouse, parents or others to obtain dental or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Cirocco Dental Center to release my medical and/or billing information to the following individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Patient, Parent or Guardian _____ Date _____

CIROCCO DENTAL CENTER

5280 PA Route 309
Center Valley • PA •18034

(610) 282-1278

Consent For Treatment & Financial Agreement

Patient Name: _____

Date of Birth: _____

CONSENT FOR TREATMENT

1. I hereby authorize the Doctor or designated staff to evaluate, diagnose, prevent and / or treat (nonsurgical, surgical, or related procedures) any diseases, disorders and / or conditions of the oral cavity, maxillofacial area and / or the adjacent and associated structures and their impact as it relates to myself. I also authorize the doctor to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my medical and / or dental needs, and allow the doctor to use the aforementioned information for scientific and/or clinical purposes provided my identity is not revealed.
2. Upon such diagnosis, I authorize the Doctor to perform any and all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. This includes medically related exams, consultations, CT, and radiographs; and dentally related care such as root canal treatment, oral surgery, dental implant, and prosthetic (crowns, bridges, dentures) treatments that have been prescribed to me.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that the use of anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I understand that the practice of dentistry is not an exact science and that therefore, results cannot be fully guaranteed. I understand that the teeth are living and biological structures of the human body, and complications may arise during and after any form of treatment which may require the need for a specialist.
5. I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not visible during examination. The most common example of this is necessary root canal therapy or additional restorative care following routine restorative procedures. I give permission to the Doctor to make any and/or all changes and additions as necessary.

FINANCIAL AGREEMENT

1. I agree to pay all fees and charges for such treatment. I agree to pay all charges for members of my family shown by statements, promptly upon presentation thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing date. In the event legal action should become necessary to collect an unpaid balance due for dental services rendered to me or my family. I / we agree to pay reasonable attorney's fees or other such costs as the Court deems proper.
2. It is agreed that all payments will not be delayed or withheld because of any insurance coverage or the dependency of claims thereof, and proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. In other words, if your insurance company does not reimburse this office, you are solely responsible for all payments to this office. If any discrepancy with your insurance company should arise, we will expect you to pay within 30 days of notification of the discrepancy. A copy of this assignment is valid as the original.
3. If financial arrangements have been made and payments are delinquent, this office reserves the right to reschedule any non-emergency appointments until the account is brought to current status.
4. It is the patient's responsibility for knowing their medical & dental insurance company coverage, even if this office is a participating provider. Not all insurance coverage is the same, even if coverage is within the same company. The patient is responsible for all co-pays and deductibles at the time of service. We reserve the right to bill your medical and dental insurance plan for any related care.

5) Forms of payment include cash, check, or credit card. Discounts or limited time offers may apply for some procedures at our company's discretion. Our office also reserves the right to charge for appointments cancelled or broken without proper advanced notice.

I have had the opportunity to read and understand this form and ask questions. I agree to the consent for treatment and the insurance / financial agreement.

Signature of Patient, Parent or Guardian _____ Date _____

CIROCCO DENTAL CENTER
5280 PA Route 309
Center Valley • PA •18034
(610) 282-1278

HIPAA Privacy

Patient Name: _____

Date of Birth: _____

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose.
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices.
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence.
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws.
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies.
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime. to provide information about a crime at our office; or to report a crime that happened somewhere else.
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations.
- Uses or disclosures for health-related research.
- Uses and disclosures to prevent a serious threat to health or safety.
- Uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials. for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service.
- Disclosures of de-identified information.
- Disclosures relating to worker's compensation programs.
- Disclosures of a "limited data set" for research, public health, or health care operations.
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures.
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

• Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.

• Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

• Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

• Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

• Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

• Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

Signature of Patient,
Parent or Guardian _____ Date _____