Somerset Dental Associates

Somerset

1590 North Center Avenue
Somerset, PA 15501
(814)444-8815

Johnstown

865 Eisenhower Boulevard
Johnstown, PA 15904
(814)444-1606

PATIENT INFORMATION

Patient Full Name: _____ Date of Birth: _____

Patient Marital Status: **CHILD** **SINGLE** **MARRIED** **DIVORCED** **SEPARATED** **WIDOWED**

Patient Race: _____ Patient Sex: **MALE** **FEMALE**

Patient Social Secuity #: _____

Patient Address:

_____

_____

Patient Phone Numbers:

Home: _____
Work: _____ Ext: _____
Cell: _____
Emergency: _____ Emergency Contact: _____

IF PATIENT IS UNDER 18 YEARS:

Patient Parent/Guardian Full Name: _____

Parent/Guardian Date of Birth: _____

Parent/Guardian Address - if different from above:

_____

APPOINTMENT POLICY

If you do not come to your assigned appointment, you will receive a letter informing you that your appointment was missed. If a second appointment is missed, you will receive a dismissal letter from the practice. It is very important to call this office as soon as you know that a scheduled appointment does not work for you or your family member. We require at least **24 hour** notice of a cancellation. There is a high demand for appointments and your cancellation will allow us to offer your time to another patient in need. Please remember to also call this office if your phone number changes. **If your phone is disconnected, your voicemail is not set up, or if we simply cannot reach you, you will be removed from the schedule until we hear from you.**

MISSED APPOINTMENTS: Unless canceled at least 24 yours in advance, our policy is to charge for missed appointments at a rate of $50 per scheduled appointment. Please help us serve you better by keeping scheduled appointments.

By signing below, you agree to call this office to cancel an appointment within our guidelines AND you also agree to call this office when your number has changed.

Patient or Parent/Guardian Signature: _____ **Date:** _____

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Patient Name: **Date of Birth:**

Medical History-Adult:
Height: _____ Weight:_____

Are you allergic to or had an adverse reaction to any of the following?
Check all that apply:

__ Aspirin
__ Ibuprofen
__ Codeine
__ Sulfa Drugs, Sulfites, Sulfides
__ Erthromycin
__ Nitrous Oxide
__ Acetaminophen/Tylenol
__ Penicillin
__ Barbiturates
__ Tetracycline
__ Other Antibiotics - Specify: _____
__ Local Anesthesia
__ Latex, Metals, Plastic
__ Food - Specify: _____
__ Dyes

Please list any other allergies: _____

Check any of the following you currently have or had in the past:

__ Heart Disease
__ Heart Attack (Year: ____)
__ Artifical Heart Valve
__ Pacemaker
__ High Blood Pressure
__ Heart Stents
__ Angina/Chest Pain
__ Stroke (Year: _____)
__ Epilepsy/Seizures
__ Head Injury
__ Headaches
__ Fainting
__ Liver Disease
__ Kidney Disease
__ Diabetes
__ Thyroid Disease
__ Glandular Disorder
__ Anemia
__ Smoke/Vape
How long? _____
How much? _____
__ Blood Disease
__ Bleeding Disorders
__ Glaucoma
__ Sinus Issues
__ Asthma
__ COPD/Emphysema
__ Shortness of Breath
__ Tuberculosis
__ Sleep Apnea (Snoring)
__ Arthritis
__ Osteoporosis
__ Artificial Joints/Implants
__ Anxiety
__ ADHD
__ ADD
__ Autism
__ Down's Syndrome
__ Developmental Delays
__ Malignant Hyperthermia
__ Depression
__ Cerebral Palsy
__ Parkinson's Disease
__ Mental Disorder
__ Shingles
__ MRSA
__ Hepatitis A, B, C
If yes, specify _____
__ Herpes
__ AIDS, HIV+
__ History of Drug Addiction
__ History of Alcoholism
__ Cancer, Chemotherapy, Radiation
If yes, specify _____
__ Hard of Hearing
__ PTSD
__ Currently Pregnant
If yes, due date _____
__ Currently Breastfeeding

Other: _____

Major Surgeries (Type and Date): _____

Patient Name:	Date of Birth:

1. Name of Family Physician? Please list physician's phone number.
   _____Phone Number _____
2. Are you taking any medications at this time? **YES** **NO**
   If yes, please list all medications or present a list of medications
   _____
3. Has there been any change in your health in the last year? **YES** **NO**
   If yes, please explain:_____
4. Can you walk up a flight of stairs without getting short of breath? **YES** **NO**
5. Has your physician ever told you to take antibiotics prior to dental visits? **YES** **NO**
   If yes, for what condition: _____
6. Do you currently have a cold, cough, flu, runny nose, or congestion of the head or chest? **YES** **NO**
7. Do you use chewing tobacco? **YES** **NO** If yes, how long? _____ How often? _____
8. Have you ever used illegal drugs? **YES** **NO**
9. Do you drink alcohol? **YES** **NO** If yes, how often? _____
10. Do you consume energy drinks? **YES** **NO** If yes, how often? _____
11. Have you ever had surgery or radiation for a tumor/growth of your head or neck? **YES** **NO**
12. Have you ever had any serious issues related to dental treatment? **YES** **NO**
13. Have you or anyone in your family had any adverse reactions to anesthesia? **YES** **NO**
14. Are you currently taking Fosamax or any Bisphosphonate for osteoporosis? **YES** **NO**
15. Is there any possibility that you are pregnant? **YES** **NO**
16. How were you referred to our office? _____
17. Race (Please check all that apply):

__ African American __ Asian __ Alaskan Native __ Caucasian
__ Hispanic __ Native American __ Native Hawaiian __ Other __ I refuse to answer

I understand that withholding any information about my health could jeopardize the safety of my health. I have reviewed this form and answered all quesitons to the best of my knowledge.

Patient Signature: _____ **Date:** _____

If under 18:
Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____ **Date:**_____

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Patient Name:	**Date of Birth:**

Primary Insurance	**Secondary Insurance**
Subscriber Name: _____	Subscriber Name: _____
Subscriber ID: _____	Subscriber ID: _____
Date of Birth: _____	Date of Birth: _____
Relationship to Subscriber: _____	Relationship to Subscriber: _____
Employer Name: _____	Employer Name: _____
Employer Phone: _____	Employer Phone: _____
Insurance Company: _____	Insurance Company: _____
Insurance Group: _____	Insurance Group: _____
Insurance Phone: _____	Insurance Phone: _____

Please present your insurance card to be photocopied for our records.

Authorization for Release of Information to Family Members:

Many of our patients allow family members such as their spouse, parents or others to call and request medical 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 medical 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 Somerset Dental Associates to release my medical and/or billing information to the following individual(s):

1 _____ **Relationship to Patient:** _____

2 _____ **Relationship to Patient:** _____

3 _____ **Relationship to Patient:** _____

Patient Signature: _____ **Date:** _____

If under 18:
Parent/Guardian Signature: _____

Parent/Guardian Name (Please Print): _____

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Patient Name: _____ Date: _____

Somerset Dental Associates is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DENTAL PROFESSIONAL
- FULL PAYMENT IS DUE AT TIME OF SERVICE
- WE ACCEPT CASH, CHECKS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT
- SDA PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

UNACCOMPANIED MINORS

The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, Master Card or Discover.

INSURANCE:

Somerset Dental Associates (SDA) provides insurance company billing as a **courtesy** to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. The amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceeds these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by SDA staff regarding his/her remaining benefit in any such benefit period.

- The claims we submit to insurance companies indicate that you have assigned those benefits to SDA. However, if you are paid by the insurance company instead of SDA, you then become responsible for the total account balance and payment would be expected immediately.
- If you or your family has more than one dental insurance program, we will assist you in obtaining the maxium benefits available.
- You as a patient are always responsible for any charges that are not covered by your insurance.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature: _____ **Date:** _____

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HIPAA

Patient Full Name:_____ Date of Birth:_____

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However any use of disclosure that occured prior to the date I revoke this consent is not affected.

Consent For Treatment

I consent to be a patient of the aboved named office and agree to a radiographic and clinical examination. I also understand and consent to the following:

- During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum greatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.
- I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my medical history.
- No guarentees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated restults.
- I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or procedure has been preapproved, I am responsible for any costs that my insurance does not cover.
- My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.
- I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

I, _____, am the parent or legal guardian of _____ ("Minor Child"), who is not emancipated and under age 18. By signing this form, I authorize _____ ("Designated Adult") to consent to or refuse dental care or treatment for Minor Child that is recommended by Somerset Dental Associates. I understand that my authorization is given prior to any dental treatment or recommendation. However, this authorization empowers Designated Adult with authority to exercise his/her best judgement upon the advice of SDA dental provider, and consent to or refuse any dental care or treatment for Minor Child.
Name of Designated Adult (please print):_____

Patient or Parent/Guardian Signature:_____ Date: _____
Parent/Guardian Name (please print):_____
Relationship to Patient:_____