CONESTOGA ORAL SURGERY
leading the way

Date: _____/_____/_____
Referred by: □ Doctor:_____
□ Other:_____

PATIENT INFORMATION

Name:_____/_____/_____ Address:_____ /_____/_____/_____
First Name M.I. Last Name Street City State Zip

Date of Birth:___/___ /_____ Age:____ Sex: M / F Social Security #____/___/_____ Marital Status: □ S □ M □ D □ W

Home#:(____)_____ -_____ Cell#:(____)_____-_____ Work#:(___)_____-_____

Employer/Department:_____/_____ □ FT □ PT □ Retired □ Student: High School / College

Medical Physician:_____ Dentist_____ Orthodontist:_____

Have you or your family been here before: □ Yes □ No Family Member Name:_____

Emergency Contact Name: _____ Phone#:(____)_____

GUARANTOR INFORMATION:

(Please complete if person responsible is other than the patient)

Name:_____/_____/_____ Relation to Patient: _____
First Name M.I. Last Name

Home Address:_____ /_____/____/_____ Employer/Dept:_____/_____
Street City State Zip

Date of Birth:_____ Social Security#:_____ ____ _____ Marital Status: □ S □ M □ D □ W

Home#:(____)_____ _____ Cell#:(____)_____ _____ Work#:(____)_____ _____

PRIMARY INSURANCE INFORMATION

Medical Insurance:	Dental Insurance:
Insurance Address:	Insurance Address:
Insured Party:	Insured Party:
Insured's DOB:	Insured's DOB:
Insured's SS#:	Insured's SS#:
Relation to Patient:	Relation to Patient:
Insured ID#:	Insured ID#:
Group#:	Group#:
Employer Name:	Employer Name:

SECONDARY INSURANCE INFORMATION

Medical Insurance:	Dental Insurance:
Insurance Address:	Insurance Address:
Insured Party:	Insured Party:
Insured's DOB:	Insured's DOB:
Insured's SS#:	Insured's SS#:
Relation to Patient:	Relation to Patient:
Insured ID#:	Insured ID#:
Group#:	Group#:
Employer Name:	Employer Name:

_____ _____ _____
Patient's (or Legal Guardian Signature) **Print Name** **Date**

Conestoga Oral & Maxillofacial Surgery, ltd
<u>Financial Policy and Agreement</u>

We value our patients and are committed to the highest quality of care from our Board Certified Surgeons. We are proud to discuss our fees or office financial policy at any time.

A Driver's License and any insurance cards must be presented the day of your visit and will be photocopied for our records.

Non-Insured Patients:
Payment for dental treatment is due the day services are rendered. I understand that fees will be collected by the front desk upon presenting for an appointment to allow our patients to depart immediately following treatment. We accept cash, personal checks, Visa, Master Card, Discover, Care Credit and Wells Fargo. Our office can assist you if interested in applying for Wells Fargo.

Insured Patients:
Patients covered by an insurance carrier who pays the patient directly will be considered non-insured and must follow the office financial policy for non-insured patients. A receipt will provided to you at the time of payment which you can forward to your insurance carrier for reimbursement.

Insurance coverage is a benefit of the patient not our facility. It is your responsibility to know the specifics of your policy. As a courtesy to our patients, we will obtain information available regarding your plan coverage and will provide an ***estimate*** *of your expected co-pay for recommended treatment upon completion of your consultation. Our estimate will be as accurate as possible. Please understand that the fees paid by your insurance company are according to their own fee schedule, not necessarily the actual fees and cost of treatment performed by our office. Any estimated patient co-pays will be collected by the front desk upon presenting for an appointment to allow our patients to depart immediately following treatment. Unfortunately, we may not be aware of your specific plans limitations which may result in a payment that differs from our estimate or actual cost of your treatment such as:*

- *Missing tooth clause*
- *Procedures which are not a benefit*
- *Inaccurate information received from the patient*
- *Annual benefit maximum being reached*
- *Changes or termination of coverage*

(Fees resulting from limits and exclusions are the patient's responsibility.)

- ***I understand and agree that I am responsible for payment of all charges on my account regardless of any estimates of fees and/or insurance coverage provided by your facility.***
- ***I understand and agree that after my insurance carrier processes my claim(s), there could be a balance still remaining to be paid by me and must be paid immediately upon receipt of statement.***
- ***I understand and agree that if my account is placed into collection action, I will be responsible for all the costs of such action including but not limited to collections agency fees, attorney fees and District Justice fees.***
- ***I understand that I am responsible for any fees as a result of a bad check and a that a claim will be filed with the Bad Check Restitution Program of the Lancaster County District Attorney's Office.***
- ***I hereby authorize payments directly to Conestoga Oral & Maxillofacial Surgery, ltd. For insurance benefits otherwise payable to me.***

_____ _____
Patient's (or Legal Guardian) Signature ***Date***

HEALTH HISTORY

Patient's Name:_____ **Age:**_____ **Height**_____ **Weight:**_____ **Date:**_____

Chief Dental Complaint:_____

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Are you now under a physician's care? ..... Y N
4. If yes, specify:_____
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N

_____

_____

6. DO YOU HAVE OR HAVE YOU EVER HAD:
- A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
- B. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Chest Pain Palpitations, Heart Surgery, Pacemaker)? ..... Y N
- C. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath)? ..... Y N
- D. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? ..... Y N
- E. Bleeding Disorder, Anemia, Blood Transfusion? Y N
- F. Do you bruise easily? ..... Y N
- F. Liver Disease (Jaundice, Hepatitis)? ..... Y N
- G. Kidney Disease? ..... Y N
- H. Diabetes? ..... Y N
- I. Thyroid Disease? ..... Y N
- J. Arthritis? ..... Y N
- K. Stomach Ulcers or Colitis? ..... Y N
- L. Eye disease/glaucoma ..... Y N
- M. Osteoporosis? ..... Y N
- N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
- O. Radiation/Chemotherapy treatment? ..... Y N
- P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
- Q. Sinus or Nasal problems? ..... Y N
- R. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
- S. HIV/AIDS ..... Y N
- T. Mental Health problems ..... Y N
- U. Are you on a diet or have an eating disorder? ..... Y N
- V. Sexually Transmitted Disease ..... Y N
- W. Do you premedicate with antibiotics? ..... Y N

7. ARE YOU USING ANY OF THE FOLLOWING:
- A. Anticoagulants (Blood Thinners, Coumadin, Plavix, Aspirin)? ..... Y N
- B. Steroids (Cortisone, Prednisone, etc.)? ..... Y N
- C. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers? ..... Y N (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia)
- D. Have you ever been advised <u>not</u> to take a medication? ... Y N
- E. **Please list any and all medications** taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:

_____

_____

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:
- A. Local Anesthesia (Novocain, etc.)? ..... Y N
- B. Penicillin or other antibiotics? ..... Y N
- C. Sedatives? ..... Y N
- D. Aspirin or Ibuprofen? ..... Y N
- E. Codeine or other pain killers? ..... Y N
- F. Latex or Rubber products? ..... Y N
- I. Food products? ..... Y N
- J. Other allergies or reactions? Please list ..... Y N

_____

_____

9. Do you smoke or chew Tobacco? ..... Y N
How much per day? _____
10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder? ..... Y N
11. Have you or an immediate family member had any problem associated with anesthesia? ..... Y N
12. Do you have any other disease, condition or problem not listed above? ..... Y N

13. FOR WOMEN ONLY
- A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant? ..... Y N
- B. Are you nursing? ..... Y N
- C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I have read and understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist.

_____ **Date** | _____ **Signature of Patient/Guardian** | _____ **Assistant's Initials**

DOCTOR COMMENTS:_____

Date: _____ **Dentist's Signature:** _____

HEALTH HISTORY CONTINUED……

Patient's Name_____ **Date**_____

Additional Information (medications, illnesses or surgeries)::

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____ _____

Date **Signature of Patient/Guardian** **Assistant's Initials**

_____ _____

Date **Doctor's Signature**

Michael P. Eckhart, D.D.S.
Gary W. Seldomridge, D.M.D.
Andrew P. Heise, D.M.D., M.D.
Daniel P. Henrichsen, D.M.D.
Brandon R. Iverson, D.D.S.
Gregory S. Bell, D.D.S.
Mona M. Stone, D.D.S.

(717) 394-3033
Info@conestogaoms.com

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.

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 (04/15/03), 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.

Medical records of all patients will be maintained on file for at least seven years following their last visit with this practice. Records of minors will be maintained until the reach the age of twenty (if they do not reach this age after seven years).

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 and 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 communications 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 you $0.25 for each page, $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative

format, we will charge a cost-based fee for providing your health information in that format. 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 years, 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.

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 you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

190 Good Drive Lancaster, PA 17603	8194 Adams Drive Hummelstown, PA 17036	2310 Rothsville Road Lititz, PA 17543

www. Conestogaoms.com

CONESTOGA
ORAL SURGERY
leading the way

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
You May Refuse to Sign This Acknowledgement

I attest the "Notice of Privacy Practices" was made available to me.

(Print Patient Name) (Date)

(Print Guarantor Name) (Guarantor Signature)

For Office Use Only

We attempted 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)_____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home/Cell Telephone: /

☐ Ok to leave message with detailed information
☐ Leave message with call-back number only
☐ Ok to give information to family member or other person

If yes, please specify their name:_____Relationship to you:_____
If yes, please specify their name:_____Relationship to you:_____

Work Telephone:

☐ Ok to leave message with detailed information
☐ Leave message with call-back number only

Written Communication

☐ Ok to mail to my home address
☐ Ok to mail to my work/office address
☐ Ok to fax
☐ I agree to permit discussions of my medical/dental care with my employer or benefits personnel.

The following individuals may be contacted to discuss my medical care if necessary:

Name(s) Relationship Phone

1._____
2._____
3._____

This information will be considered current & valid unless otherwise notified.

Name Signature Date

717-394-3033

190 Good Drive
Lancaster, Pa 17603
Fax: 717-394-5378

8194 Adams Drive
Hummelstown, Pa 17036
Fax: 717-482-8403

2310 Rothsville Rd
Lititz, Pa 17543
Fax: 717-625-2202

•Michael P. Eckhart, D.D.S. •Gary W. Seldomridge, D.M.D. •Andrew P. Heise, D.M.D., M.D.
•Daniel P. Henrichsen, D.M.D. •Brandon R. Iverson, D.D.S. • Gregory S. Bell, D.D.S. • Mona Stone, D.D.S.