WEST PENN DENTAL CENTER, LLC
Family Dental Care
312 2nd Avenue, Carnegie, PA 15106
(412) 279-PENN (7366) Fax: (412) 279-4067

Patient HIPAA Consent

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 (i.e. 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 that you are not required to agree to these requested restrictions. However, if you do disagree, 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 or disclosure that occurred prior to the date I revoke this consent is not affected.

Signature_____

Printed Name _____

Date ___/____/_____

I authorize the following people to receive information about my medical care, treatment, billing, and history:

Name _____ Relationship _____ Phone number _____

Insurance Policies Explained

While it may be very evident to some patients, not every person is aware of the basics of insurance. Simply having insurance is not a guarantee that a particular treatment is covered. While we will submit any and all applicable claims to your insurance, the insurance company may decline to pay for a procedure. At that point, payment for services are now the responsibility of the patient.

Some procedures are not covered by insurance, and those treatments will be the financial responsibility of the patient. These procedures can be declined for many reasons, if they are not covered benefits or for frequency of procedure.

Patients should read over their benefits package to be aware of the basics of their coverage. Some insurances have deductibles, this is the responsibility of the patient and is due at the beginning of any non-preventative service (anything other than cleanings and exams). Copayments are due at the time of service.

Major services (crowns, bridges, implants, relines, dentures/partials, root canals) will always be submitted to your insurance company for an approval prior to starting treatment to see what percent of the treatment they will cover. However, if insurance coverage ends during the treatment process, it will be the responsibility of the patient to cover the remaining balance of any continued treatments.

We will NEVER ask for payment before a procedure is started.

We will always be honest and fair with pricing, but non-payment for rendered services is unacceptable. Balances are mailed out on a monthly bases, if enough time passes without payment we can and will involve a collection agency.

Signature _____

Printed Name _____

Date____/____/_____

All appointments MUST be confirmed. If an appointment is not confirmed it may be filled. Any cancelations MUST be made 24 hours or more from the appointment time. If a patient cancels or no shows 3 times or more they will NOT be rescheduled at this office.

Signature _____

Printed Name _____

Date____/____/_____

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Patient Intake Form

Welcome to West Penn Dental. It is our sincere hope that your visits here will be comfortable and satisfying. Please take a few minutes to complete this confidential questionnaire so we can provide the best treatment for you.

Patient Name _____Birthdate____/____/____ Sex_____

Marital Status_____Address_____

Phone _____ Email_____

Social Security Number_____ Referred By_____

Insurance Subscriber Information (If insurance is through a spouse or guardian)

Name_____ Birthdate____/____/_____ Sex _____

Phone_____ Address _____

Social Security Number_____ Employer_____

Employer's Phone/ Email _____

Employer's Address _____

Dental History

Last Dental Appointment _____ Was Planned Treatment Completed _____

Do You Have X-Rays _____ Any Current Discomfort _____

Have You Lost Any Teeth _____ Any Complications with Extractions _____

Do You Have a Denture/Partial _____ How Old is Appliance _____

Is there Fluoride in Your Water _____ Do You Take Fish Oil _____

Do You Use Any Tobacco Products _____ What Kind _____ How Much/Often_____

General Health Information

Are You Pregnant _____ Due Date _____ /_____ /_____

Primary Care Provider_____ Phone_____ Date of Last Exam ____ /____ /____

□ Heart Problems □ High Blood Pressure □ Low Blood Pressure

□ Circulatory Issues □ Diabetes or Hypoglycemia □ Joint Replacement/Artificial Limbs □ Stroke

□ Anemia □ Excessive Bleeding □ Heart Murmur □ Pacemaker □ Aids □ Tuberculosis □ Ulcer

□ Radiation Treatment □ Malignancies □ Arthritis □ Asthma □ Epilepsy □ Mumps

□ Rheumatic Fever □ Scarlet Fever □ Sinus Problems □ Tonsillitis

□ Psychiatric Care □ Anxiety □ Seizure Disorder □ Allergy to Anesthetics □ High Cholesterol

□ Hepatitis (Date ____ /____) Still Active? ____

Other Medical Conditions? _____

Are You Taking any Blood thinners? ____ If So, Which? _____

Are You Taking any Medications for Osteoporosis? ____ If So, Which? _____

Current Medications / Dose (if you have a physical copy please provide to front desk):

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies (please list): _____

Previous Surgeries (please list): _____

Signature: _____ **Date:** _____ /_____ /_____