CEDAR CREST DENTAL CARE

1251 S. Cedar Crest Blvd., Suite 207C | Allentown, PA 18103 | (610) 437-9000

New Patient Form

Please print clearly, complete every applicable section, sign the form, and bring it with you to your appointment.

Vinky S. Pathak, D.D.S. | Linda T. Warren, D.D.S. | Nardine Bastawros, D.D.S.

1. PATIENT INFORMATION

Today's date _____ Last name _____ First name _____

Middle initial _____ Preferred name _____ Birth date _____

Social Security number _____ Sex: [ ] M [ ] F _____ Marital status _____

Street address _____

City _____ State _____ ZIP code _____

Email address _____

Home phone _____ Work phone _____ Cell phone _____

Employer _____ Occupation _____

Whom may we thank for referring you?

2. RESPONSIBLE PARTY

Person responsible for account _____ Relationship to patient _____

Birth date _____ Social Security number _____ Currently a patient? [ ] Yes [ ] No

Street address _____

City _____ State _____ ZIP code _____

Home phone _____ Work phone _____ Cell phone _____

Employer _____

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3. PRIMARY DENTAL INSURANCE

Name of insured _____ **Relationship to patient** _____

Insured birth date _____ **Member or ID number** _____ **Group number** _____

Insurance company _____ **Insured's employer** _____

Insurance mailing address _____

City _____ **State** _____ **ZIP code** _____

4. SECONDARY DENTAL INSURANCE

Name of insured _____ **Relationship to patient** _____

Insured birth date _____ **Member or ID number** _____ **Group number** _____

Insurance company _____ **Insured's employer** _____

Insurance mailing address _____

City _____ **State** _____ **ZIP code** _____

5. DENTAL HISTORY

Previous dentist _____ **Previous dentist phone** _____

Date of last X-rays or examination _____

Check every condition you currently have or have had in the past:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth
- ☐ Broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold or hot
- ☐ Jaw pain
- ☐ Sores in mouth

Dental history details or other concerns

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6. MEDICAL HISTORY

Physician name _____ **Physician phone** _____

Complications following dental treatment - explain and include dates

Hospital admission or emergency care - explain and include dates

Serious illness or operations - explain and include dates

Blood transfusion - explain and include dates

Pregnancy - details and expected due date, if applicable

Check every condition you currently have or have had in the past:

- ☐ Premed
- ☐ Arthritis or rheumatism
- ☐ Blood disease
- ☐ Dizziness
- ☐ Fainting
- ☐ Head injuries
- ☐ Heart murmur
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Mitral valve prolapse
- ☐ Respiratory problems
- ☐ Seizures
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Allergies
- ☐ Artificial joints or valves
- ☐ Cancer
- ☐ Excessive bleeding
- ☐ Glaucoma
- ☐ Hearing problems
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Liver disease
- ☐ Pacemaker
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Thyroid disorders
- ☐ Ulcers
- ☐ Anemia
- ☐ Asthma
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Headaches
- ☐ Heart condition
- ☐ High blood pressure
- ☐ Jaundice
- ☐ Mental or nervous disorders
- ☐ Radiation or chemotherapy
- ☐ Rheumatism
- ☐ Stomach problems
- ☐ Tobacco habit
- ☐ Venereal disease

Current medications and corresponding diagnosis

Allergies

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7. AUTHORIZATION AND RELEASE

To the best of my knowledge, the information on this form is complete and correct. I understand that it is my responsibility to inform Cedar Crest Dental Care if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have the insurance coverage I have provided and assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that all dental services furnished are charged directly to the patient and that the patient is personally responsible for payment. The office will help prepare insurance forms or assist in making collections from insurance companies and will credit collections to the patient account. The office cannot render services on the assumption that charges will be paid by an insurance company. I authorize the use of my healthcare information and my signature on insurance submissions for obtaining payment and determining benefits.

A service charge of 1 1/2% per month (18% per year) on the unpaid balance will be charged on accounts exceeding 60 days unless previously written financial arrangements are satisfied.

☐ I have read the conditions of treatment and payment and agree to them.

Patient signature _____ **Date signed** _____

Guarantor or responsible-party signature _____ **Relationship to patient** _____

8. NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The complete Notice of Privacy Practices is included on the following pages. Please review it before signing this acknowledgement. You may refuse to sign; refusal will not change how your health information is handled.

☐ I acknowledge that I was given the opportunity to review Cedar Crest Dental Care's Notice of Privacy Practices.

Printed name _____ **Signature** _____ **Date** _____

BEFORE YOUR APPOINTMENT

Review the form for completeness. Bring this filled and signed form to Cedar Crest Dental Care when you come in for your appointment.

Questions: (610) 437-9000 | info@ccdc.dentist | ccdc.dentist

Notice of Privacy Practices

Cedar Crest Dental Care | Vinky S. Pathak, D.D.S. | Linda T. Warren, D.D.S. | Nardine Bastawros, D.D.S.

1251 S. Cedar Crest Blvd., Suite 207C, Allentown, PA 18103 | 610-437-9000

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 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 04/14/2003, 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 changes in our privacy practices and the new terms of our notice effective for all health information that we maintain. 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, please contact us using the information listed at the end of this notice.

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 or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use or 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 or 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 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.

Person Involved in Care: We may use or disclose your 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 Service: 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, counter-intelligence, and other national security activities. We may disclose to correctional institutions or law-enforcement officials having lawful custody the protected health information of an 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, text messages, 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 practically 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 at the end of this notice.

Disclosure Accounting: After 04/14/2003, 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, or other activities, for the last six years. If you request this accounting more than once in a two-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 and 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 this 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.

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 have violated your privacy rights, or you disagree with a decision 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 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 may also submit a written complaint to the U.S. Department of Health and Human Services.

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 the U.S. Department of Health and Human Services.

Contact Officer: Kelly Borst | Telephone: 610-437-9000 | Address: 1251 S. Cedar Crest Blvd., Suite 207C, Allentown, PA 18103 | Email: info@ccdc.dentist