Patient Information Form

Patient Information:

Last Name:	First Name:	Middle Initial:
DOB:	Age:	Social Security Number:
Address:		
City:	State:	Zip Code:
Wireless Phone:		
Home Phone:		
E-mail:		

Primary Insurance:	Secondary Insurance:
Insurance Carrier:	Insurance Carrier:
Employer:	Employer:
Group Number:	Group Number:
Subscriber Name:	Subscriber Name:
Subscriber SSN:	Subscriber SSN:
Member ID:	Member ID:
DOB:	DOB:

Emergency Contact Information:

Name of Contact:

Phone Number:

Relationship to Patient:

May we communicate information with this individual concerning your care? ☐ Yes ☐ No

Authorization:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any of my health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts. By signing this statement, I am agreeing to responsibility of services not paid in full or part by my dental care payer.

I attest to the accuracy of the information on this page.

Patient or Guardian Signature Date

Dental History:

Patient Name:

Reason for today's visit: Date of last Dental visit:

Former Dentist: Date of last Dental X-rays:

Indicate which of the following you have had or have at present.

- Bad breath
- Blisters on lips or mouth
- Burning Sensation on tongue
- Chew on one side of mouth
- Cigarette, pipe, or cigar smoking
- Smokeless Tobacco
- Dry mouth
- Food Collection between teeth
- Clench or grind teeth
- Growths or sore spots in your mouth
- Gums swollen, tender or bleeding
- Head, neck, jaw pain, or aches
- Lip or cheek biting
- Loose teeth or broken fillings
- Mouth breathing
- Orthodontic treatment
- Nitrous Oxide
- Periodontal Treatment
- Sensitivity to pressure, cold, heat or sweets

Have you ever had an allergic reaction to Novocaine, local or general anesthetics? ☐ Yes ☐ No
If Yes, please explain:

Have you ever had trouble from previous dental care? ☐ Yes ☐ No
If Yes, please explain:

Medical History:

Physician's name: Address:

Date and reason for last visit:

Indicate which of the following you have had or have at present. By checking the box, it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ***Pre-Medication
- Abnormal bleeding
- Alcohol use/consumption
- Allergy - Latex
- Allergy - medications (Explain below)
- Anemia
- Arthritis, Rheumatism
- Artificial heart valves
- Artificial joints
- Asthma
  - Required hospitalization
  - Have you used steroids
  - Date of last episode

  _____
- Bisphosphonates (Fosomax, Actonel, Boniva, Reclast, Didronel, Zometa ect.)
- Blood disease, clotting disorder
- Blood thinners
- Cancer
- Chemical dependency
- Chemotherapy
- Circulatory problems
- Contact lenses
- Cortisone treatments
- Cough, persistent or bloody
- Diabetes
- Emphysema
- Epilepsy
- Fainting
- Glaucoma
- Headaches
- Heart murmur
- Heart problems
- Hepatitis type _____
- Herpes
- High Blood Pressure
- Any immune deficiency
- Jaundice
- Kidney Disease
- Low Blood Pressure
- Mitral valve prolapse
- Osteoporosis
- Osteopenia
- Pacemaker
- Pregnant/Nursing:
  Due Date: _____
- Radiation treatments
- Respiratory disease
- Rheumatic fever
- Scarlet fever
- Seasonal Allergies, hay fever, sinusitis
- Shortness of breath
- Sinus trouble
- Sickle cell anemia
- Skin Rash
- Slow healing wounds
- Stroke
- Swelling of feet or ankles
- Thyroid problems
- Tonsillitis
- Tuberculosis
- Tumor or growth on head/neck
- Ulcer
- Venereal disease
- Weight loss, unexplained
- Other (Explain below)

ALLERGIES – List any allergies that you have below:

_____ _____
_____ _____
_____ _____

Other conditions not listed or that needs further explanation:

_____
_____
_____

MEDICATIONS - List any medications that you are taking below:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Authorization and Release:

I have read and answered the above questions to the best of my knowledge.

_____
Patient/Guardian Signature **Date**

_____
Doctor Signature **Date**

MICHAEL G. SOPHOCLES, D.M.D.

AND ASSOCIATES

NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I,_____ have seen a copy of this office's Notice of Privacy Practices.

_____ _____

(Signature) (Date)

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
_____ Communications barrier prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (please specify below)

_____

_____

Michael G. Sophocles, D.M.D.
And
Associates

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 practices that are described in this Notice while it is in effect. This Notice takes effect (4/7/03), and will remain in effect until we replace it.

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 provided providing treatment to you.

Payment: We may use and disclose your information to obtain payment for services we provided 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, review the competence or qualification 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, or other person to the extent necessary to help with your healthcare of with payment for 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 location) 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 interest in allowing a person to pick up filled prescription, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your 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 person 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 voice 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 that 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 sing 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 well charge you between $20 and $40 for all of your records requested. This includes 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 you 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 past six 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 disclose 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 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 provided 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 you request under certain circumstances.

Electronic Notices: 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 any 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 wit6h you by alternative means or alternative location, you may complain to 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 address to file your complaint with 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.

Contact Office: Michael G, Sophocles, D.M.D.
Telephone: 610-644-4080 fax 610-651-0127
Address: 15 Industrial Boulevard, Suite 201
Paoli PA 19301