

WELCOME

PATIENT INFORMATION

Date _____

Name _____ Birthdate _____ SS# _____ Home Phone _____

Please circle: Male/Female/Married ~ Widowed ~ Single ~ Separated ~ Divorced

Address _____ City _____ State _____ Zip _____ Cell # _____

Email Address: _____

Employer _____ Phone _____

Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

PRIMARY DENTAL BENEFIT PLAN

Name of insured _____ Birthdate _____ SS# _____

Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ ID # _____

Address _____ City _____ State _____ Zip _____

Maximum Benefits per Calendar/Contract Year _____ Deductible \$ _____

ADDITIONAL DENTAL BENEFIT PLAN

Name of insured _____ Birthdate _____ SS# _____

Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ ID # _____

Address _____ City _____ State _____ Zip _____

Maximum Benefits per Calendar/Contract Year _____ Deductible \$ _____

AUTHORIZATION AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage, and assign directly to Dr. Thomas Neslund, all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dentist may use my health care information and may disclose such information for my Insurance Company and their agents for the purpose of obtaining payment for services and determining Insurance benefits payable to related services.

Signature of Patient, Parent, Guardian or Personal Representative

Date

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No

Women: Are you _____

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs

Other If yes, please explain: _____

- Do you have, or have you had, any of the following?
- | | | | |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
| | | | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above? Yes No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

HIPAA PATIENT ACKNOWLEDGMENT AND CONSENT

I have received the Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information and have had an opportunity to read and review all contents of said document.

By signing this form, you will consent to our use and disclosure of you protected health information to carry our treatment, payment activities, and health care operations.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. These changes may apply to any of your protected health information that we may obtain.

You have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect the action we have or will take in reliance to this consent before we received your revocation, and that not signing this consent or by revoking such consent in the future, we may reserve the right to refuse treatment.

Print Name: _____

Signature: _____

Date: _____

If a personal representative on behalf of this patient signs this consent, or is appointed by you as the patient to have shared knowledge of treatment, payment activities, and health care options, please fill out the following information.

Personal Representative's Name: _____

Relationship to patient: _____

thomas p. neslund, d.m.d., p.c.

Personalized Dental Care For Your Family

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change it's *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

Brookwood Manor * 13 Brookwood Avenue, Suite 3 * Carlisle, PA 17015
717-258-5454 * Fax 717-258-5456

thomas p. neslund, d.m.d., p.c.

Personalized Dental Care For Your Family

HIPAA AUTHORIZATION FOR OTHER FAMILY MEMBERS, RELATIVES OR FRIENDS

PATIENT NAME _____

I acknowledge receipt of the HIPAA "Notice of Privacy Practices."

I will authorize disclosure of Protected Health Information to only:

NAME	RELATION
_____	_____
_____	_____
_____	_____

Signed: _____ Date: _____

Authorization if other than patient and/or parent unable to sign:

_____ Relationship _____

thomas p. neslund, d.m.d., p.c.

Personalized Dental Care For Your Family

Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing you with comprehensive, quality care. The following is a statement of our financial and insurance policy. Please read and sign.

Payment for Office Visits & Treatment

Payment for office visits and treatment is required at the completion of your visit. Pre-payment will be required for certain dental procedures. You will be informed in advance if your procedure requires pre-payment. In that event, payment will be due one week prior to your appointment. Payment can be made by cash, personal check, Visa/MasterCard, or through CareCredit our healthcare finance company. Our front office personnel will be happy to discuss payment options with you.

Practice Responsibilities

As a courtesy to our patients we will submit all claims with any necessary documentation to your insurance company.

Patient Responsibilities

Present your insurance card to the receptionist. If you do not have a card, you are responsible to provide the accurate name, mailing address, group and identification numbers of your policy. Familiarize yourself with your policy benefit package; the specific services covered, yearly maximum allowance of coverage, co-payment/insurance responsibilities, and individual/family deductibles. Understand that you will be responsible for any cost or filing fees incurred should Dr Neslund have to pursue payment of a delinquent account through a collection agency and/or attorney.

Insurance Authorization Signature on File

I hereby authorize my dental health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all health benefits due to me and my dependents.

I also authorize payment of healthcare benefits otherwise payable to me, directly to my doctor as listed above. I agree to be responsible for all charges and services not paid by my insurance company.

IMPORTANT: Insurance is a contract between you, your employer and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, covered/non-covered charges, secondary insurance, "usual and customary" charges, etc., other than to provide factual information as necessary.

Signature of Patient or Insured

Date