Welcome to PC Dental Care!

Thank you for selecting our practice to meet your most demanding dental care needs.

You may now complete our NEW PATIENT FORMS from the convenience of your home or office. This helps to ensure a smooth and faster first appointment with our team.

Please download and PRINT the new patient forms below. Then complete the forms and either mail them back to us prior to your first appointment or bring them with you to our first meeting.

We look forward to getting to know you and caring for your dental wellness!

Sincerely,

The PC Dental Care Team

PATIENT NAME _____ **DATE** _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

	Please Circle	
Do you have a specific dental problem? Describe	Yes	No
Do you have dental examinations on a routine basis? Last visit	Yes	No
Do you think you have active decay or gum disease?	Yes	No
Do you brush and floss on a routine basis? Discuss	Yes	No
Do your gums ever bleed? Discuss	Yes	No
Do you like your smile? Why?	Yes	No
Does food catch between your teeth? Any loose teeth?	Yes	No
Do you want to keep your remaining teeth?	Yes	No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind?	Yes	No
Have your past experiences in a dental office always been positive?	Yes	No
Do you smoke or chew? Any sores or growths in your mouth? Discuss	Yes	No
Name of previous dentist (optional):	Yes	No
Date of last full mouth x-rays (16 small films or panoramic):	Yes	No

Medical History

Are you under a physician's care now? Why? Who? Phone	Yes	No	
Have you ever been hospitalized or had a major operation? Discuss	Yes	No	
Have you ever had a serious injury to your head or neck? Discuss	Yes	No	
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What?	Yes	No	
Are you on a special diet? Discuss	Yes	No	
Are you allergic to any medications or substances? Please check box below	Yes	No	
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other			
Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss	Yes	No	

Do you now have or have you ever had any of the following? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment…pre-medication may be required.

	Y	N		Y	N		Y	N		Y	N		Y	N
Heart Disease/Surgery *			Anemia			Cancer			Night Sweats			Cold Sores		
Heart Murmur *			Coronary Stent			X-Ray Treatments (Radiation)			Yellow Jaundice			Fever Blisters		
Irregular Heart Beat			Excessive Bleeding			Chemotherapy			Kidney Problems			Herpes		
Angina/Chest Pain			Sickle Cell Disease			Osteoporosis			Renal Dialysis			Stroke		
Heart Attack/Failure			Hemophilia (Bleeding Problem)			Bisphosphonates Ostenonecrosis			Thyroid Disease			Convulsions		
Congenital Heart Disorder			Leukemia			Aredia I.V.			Parathyroid Disease			Epilepsy or Seizures		
Mitral Valve Prolapse *			Recent Blood Transfusion			Zometa I.V.			Arthritis/Gout			Fainting or Dizziness		
Scarlet Fever			Swelling of Limbs			Fosamax, Actonel, Boniva			Rheumatism			Glaucoma		
Rheumatic Fever *			Lung Disease			Stomach/Intestinal Disease			Pain in Jaw Joints			Tumors or Growths		
Artificial Heart Valve *			Breathing Problem			Ulcers			Cortisone Medicine			Nervousness		
Heart Pace Maker *			Shortness of Breath			Recent Weight Loss			Artificial Joint *			Psychiatric Care		
Pulmonary Shunt			Frequent Cough			Frequent Diarrhea			Venereal Disease			Alzheimer's Disease		
High Blood Pressure			Hay Fever			Diabetes			AIDS			Allergies (Medicines)		
Low Blood Pressure			Sinus Trouble			Excessive Thirst			HIV Positive			Allergies (Pollen/Dust)		
Bacterial Endocarditis			Asthma			Hypoglycemia			Genital Herpes			Hives or Rash		
Unexplained Fever			Bloody Sputum			Liver Disease			Drug Addiction/Alcoholism			Need Pre-medication?		
Bruise Easily/Blood Disease			Emphysema			Hepatitis A (Infectious)			Tattoos/Body Piercing			Ever taken fen-phen? *		
			Tuberculosis			Hepatitis B or C						Cochlear implants		

Have you ever had any other serious illness not checked above? Discuss _____ Yes No

Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____ Pulse _____

History Review and Significant Findings _____

_____

Medical Updates

I have read my MEDICAL HISTORY dated and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.

PATIENT INFORMATION

DATE

NAME _____ ☐MARRIED ☐SINGLE ☐MINOR ☐MALE ☐FEMALE
LAST FIRST
SS# _____ E-mail address _____

ADDRESS _____
STREET APT. # CITY STATE ZIP
BIRTH DATE _____ TELEPHONE _____
MONTH DAY YEAR HOME# WORK# CELL#
NAME OF EMPLOYER _____ ADDRESS _____

FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

DENTAL INSURANCE CO. _____ SUBSCRIBER # _____ GROUP # _____

Has any member of your family ever been treated in our office? ☐ YES ☐ NO
Whom may we thank for referring you to our office? _____
Do we have permission to text message dental care and appointment reminders to your cell phone? ☐ YES ☐ NO

FAMILY INFORMATION

FILL IN BOTH SHADED BLOCKS FOR MINOR CHILD.
FILL IN APPROPRIATE SHADED BLOCK FOR ADULT.

FATHER (OR HUSBAND)

_____
LAST FIRST M

_____
STREET CITY STATE ZIP

_____
HOME TELEPHONE # WORK TELEPHONE # CELL #

_____
BIRTH DATE (MO/DAY/YEAR) SS#

_____
EMPLOYER

_____
DENTAL INSURANCE CO. SUBSCRIBER # GROUP #

MOTHER (OR WIFE)

_____
LAST FIRST M

_____
STREET CITY STATE ZIP

_____
HOME TELEPHONE # WORK TELEPHONE # CELL #

_____
BIRTH DATE (MO/DAY/YEAR) SS#

_____
EMPLOYER

_____
DENTAL INSURANCE CO. SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Name
Address
City/State/ZIP
Telephone #

PERSON RESPONSIBLE FOR ACCOUNT

Please Check One
☐ Patient ☐ Father (or Husband)
☐ Guardian ☐ Mother (or Wife)

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medication and perform such diagnostic and therapeutic procedures as may be necessary for proper care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
☐ Adult Patient ☐ Father (or Husband) ☐ Mother (or Wife) ☐ Guardian
Date _____

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐ YES ☐ NO
☐ Payment in full at each appointment (cash or personal checks)
☐ Payment in full at each appointment (☐ VISA ☐ MC)
Card # _____ Exp. Date _____
☐ I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of _____ % per month (or a minimum charge of $ _____ for a balance under $ _____) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

PATIENT CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), that 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 form third-party providers.
- 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 its *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 operations. 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: _____

Your dental health is our #1 concern. We do not recommend treatment based on any insurance coverage. In order to avoid any future misunderstanding, please read and sign the following:

OUR FINANCIAL AGREEMENT FOR PC DENTAL CARE

Payment is due at the time services are rendered. For your convenience we accept cash, Visa, MasterCard, Discover, or personal check.

Insurance benefits are determined by your employer and not your dentist. Insurance is not a guarantee of payment; insurance companies will not pay for all your costs. Your insurance policy is a contract between you and your employer. Your insurance and payment are still your responsibility. As a courtesy we will be glad to file your claim for you if you bring all required employer information. You will be expected to pay for services rendered at time of service.

We reserve the right to charge and collect fees for broken appointments – appointments that are cancelled or broken without 48 hours advance notice will incur a charge of $100. Appointments are reserved exclusively for you. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise.

If a check rendered does not clear the bank and is returned to us, a fee of $35 will be added to your account balance.

Payment plans and financial arrangements can be entered into for comprehensive dental treatment, prior to commencing treatment. We also have outside 0% financing available through CareCredit and Capitol One Finance.

I have read and understand this financial policy.

PRINTED NAME SIGNATURE DATE

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 January 1, 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 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.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment: We may use or disclose health information to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care 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 health care 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 Patients 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 you with your health care or with payment for your health care, but only if you agree that we may do so.

Persons 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 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 health care. 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 to the health and 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 inmates or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards, e-mail, 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 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. You may also request access by sending us a letter to the address at the end of this Notice. 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, health care 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 explanations 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 notification 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 may also 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.