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

CARLISLE FAMILY & COSMETIC DENTISTRY

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

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:_____

49 Brookwood Ave, Carlisle, PA 17015

717-258-5455 | Fax 717-258-5456

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_____

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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

49 Brookwood Ave, Carlisle, PA 17015

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