ARIA DENTISTRY

State College Dental

Dr.Simar P. Kaur , D.D.S

OFFICE AGREEMENT

General:

I understand that regardless of any insurance status, I am responsible for the balance due on my account. I am responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

Payments:

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

Insurance:

We will be submitting an insurance claim for services rendered in our office on your behalf as convenience for you. It is your responsibility to inform us of any changes in your insurance carrier or policy. Our treatment is based on the dental need of the patient, not the insurance company benefits. We cannot render services to a patient on the assumption that the charges will be paid by the insurance company. As a courtesy we can contact your insurance company for a pre-determination of payment for major services. However, the pre-determination amount provided by the insurance company is not a guarantee of payment. We will help in any way possible to file your claim or handle any insurance queries you may have. If you do not receive any correspondence from your insurance company within 60 days of your dental visit, please contact our office to inform us of the situation.

Missed Appointments:

When appointments are scheduled, that time is set-aside specifically for you and your needs so that we may provide you with the best care. When a patient fails to come to scheduled appointment or cancels without advanced notice we are unable to provide care to another patient who is in need. With this in mind we require a notice- 48 hours or more when cancelling or rescheduling an appointment. After ONE broken appointments this practice will charge 50$ to be able to accept you back as a patient in our office. After TWO broken appointments we will no longer be able to schedule you back as a patient in our office. We do provide a confirmation call as a COURTESY REMINDER, however, you are responsible for informing us of any changes to your phone number, address, or any other contact information.

We are here to help. If you have any questions, please feel free to ask any of us.

I authorize the release of any information and/ or x-rays relating to my dental treatment to the insurance company, attorney, or collection agency in collecting the cost of the services provided. I authorize payment from my insurance company directly to my Dentist. My signature on file applies to myself and all dependents listed on my insurance plan.

I authorize the release of any information and/ or x-rays to dental offices where I have been referred or to another office of my choosing. Payment: We accept Cash, Check, MasterCard, Visa, Discover, American Express, and CareCredit Cards.

Name of Patient/ Legal Guardian:

Signature of Patient/ Legal Guardian:

Date:

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HIPAA CONSENT FORM

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decided whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your PHI and of other important matters about your PHI. A copy of our Notice accompanies with this Consent will be provided upon request. We encourage you to read it carefully and completely before signing this Consent. 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. Those changes may apply to any of your PHI that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions to our Notice, at any time by contacting our office at

Phone: (814) 238-4090

Fax: (814) 234-8435

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Consent: I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my PHI to carry out treatment, payment activities and health care operations.

Please ask for a physical copy in case you decide to revoke your consent.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

Name of Patient/ Legal Guardian:

Signature of Patient/ Legal Guardian:

Date:

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Health History

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept strictly confidential subject to applicable laws. Please note that you will be asked some questions concerning your health. This information is vital to allow us to provide you the best care possible.

General Information- Patient

Full Name - Patient:

Date of Birth

Gender : M/F

Email address:

Contact Information:

Home #

Work #

Mobile #

Patient mailing address

Patient billing address

Emergency contact

Emergency #

Family doctor name:

Family doctor #

Do you have any of the following diseases or problems:

Active Tuberculosis?

Persistent cough greater than a 3 week duration?

Cough that produces blood?

Been exposed to anyone with tuberculosis?

If you answer YES to any of the 4 items above, please stop and return this form to the receptionist.

Insurance Information

Social Security number

Occupation

Subscriber's Employer (Who do you work for?)

PLEASE BRING YOUR DENTAL INSURANCE CARD TO THE OFFICE WITH YOU FOR VERIFICATION.

Name of the Insurance Plan?

Insurance ID number:

Insurance Subscriber's Social Security Number:

Insurance Subscriber's Date of Birth:

Has your insurance information changed since your last visit?

Dental Information ("Tick/ Check" where applicable)

Do your gums bleed when you brush or floss?

Are you currently experiencing dental pain or discomfort?

Are your teeth sensitive to cold, hot, sweets, or pressure?

Do you have earaches or neck pains?

Does food or floss catch between your teeth?

Do you have any clicking, popping or discomfort in your jaw?

Have you had any periodontal (gum) treatment?

Do you grind your teeth?

Have you ever had orthodontic (braces) treatment?

Do you have any sores or ulcers in your mouth?

Have you had any problems associated with previous dental treatment?

Do you wear partial dentures?

Is your home water supply fluoridated?

Do you wear full dentures?

Do you drink bottled or filtered water? If yes, how many bottles?

Have you ever had a serious injury to your head, neck or mouth?

Date of your last dental exam? What was done at that time?

Date/Year of last dental X-rays?

Name, address and Phone number of previous dentist, if any.

Medical Information ("Tick/ Check" where applicable)

Allergies

Acetaminophen/ Tylenol®	Acrylic	Amoxicillin	Animals
Antibiotics	Aspirin	Barbiturates, sedatives or sleeping pills	Cephelex
Clindamycin	Codeine	Other narcotics	Demerol
Erythromycin	Fluoride	Food	Hay fever/ seasonal
Ibuprofen/ Motrin®/ Advil®	Iodine	Keflex	Latex
Lexapro	Local anesthetic	Mercury	Metals
Morphine	NSAIDS	Other	Penicillin
Sulfa	Tetracycline	Thimerasol	

Other

Conditions:

Abnormal/ excessive bleeding	Acid reflux	AIDS or HIV infection	Alzheimer's/ dementia
Anemia	Angina	Anxiety	Arteriosclerosis
Arthritis	Asthma	Autoimmune disease	Back problems
Blood disease	Blood Thinners	Blood transfusion	Breathing problems/ respiratory disease
Bronchitis	Cancer/ chemotherapy/ radiation treatment	Cardiovascular disease	Chest pain upon exertion
Chronic pain	Congestive heart failure	COPD	Damaged heart valves
Diabetes	Dizzyness	Eating disorder	Emphysema
Epilepsy	Fainting spells or seizures	Fear of Needles	Frequent headaches
Gastrointestinal disease	G.E. Reflux/Heartburn	Glaucoma	Gout
Hard to Freeze	Hearing difficulties	Heart attack	Heart disease
Heart murmur	Heart rhythm disorder	Hemophilia	Hepatitis
Jaundice or liver disease	High blood pressure	Joint Replacement	Kidney Disease
Kidney problems	Low blood pressure	Low pain tolerance	Lymphoma
Malnutrition	Medications	Mitral valve prolapse	Multiple Sclerosis
Neurological disorders	Night sweats	Open Heart Surgery	Osteoporosis/ Paget's disease
Other congenital heart defects	Pacemaker	Parkinson's disease	Persistent swollen glands in neck
Physical Challenges	Pregnant	Premed	Pre Medication
Psychiatric care	Recurrent Infections	Rheumatic fever	Rheumatic heart disease
Rheumatism	Rheumatoid arthritis	Severe headaches/ migraines	Severe or rapid weight loss
Sexually transmitted infection (STI)	Sinus trouble	Stents	Stomach Troubles or Ulcers
Stroke	Systemic Lupus Erythematosus	Thyroid problems	TMJ Pain
TMJ Disorder	Tuberculosis	Tumors or growths	Ulcers
Wheelchair Access	Other		

Details

Preferred pharmacy

Pharmacy #

Date of last physical exam?

Have you ever reacted adversely to any medications or injections?

Do you drink alcoholic beverages? How much/day?

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

Has there been any change to your general health within the past year?

Do you use tobacco(smoking, snuff,chew,bidis)?

Have you had a serious illness, operation or been hospitalized in the past 5 years?

Are you wearing a nicotine patch?

Are you taking any prescription or over-the-counter

medicines? (Please, get a written list).

Do you have sleep apnea?

Are you pregnant?

Are you taking birth control or hormone replacement?

Are you nursing?

Please list any surgical procedures you have undergone and when they occurred.

Have you ever taken FosaMax®, Boniva®, Actonel® or other medications containing bisphosphonates?

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Physician's phone number

Please read the above, and understand that the information provided in this form is accurate. A truthful health history will help ensure the best possible dental treatment. The information provided here will be used by the doctor and patient to inform any further discussion of the patient's health prior to or during an appointment. By signing below you also acknowledge that you will not hold the dentist, the dental practice or any other member of the practice staff responsible for any action or lack of action because of errors or omissions that may have been made during the completion of this form.

Name of Patient / Legal Guardian : ____

Signature of Patient / Legal Guardian : ____

Date : ____________________