Newtown Dentistry for Adults
PATIENT REGISTRATION

Patient Name: _____ __Married __Divorced __Single __Other
Address: _____City:_____State:____Zip:_____
Home #: _____Cell #: _____Email address: _____
Employer: _____ SS#_____ Work #: _____

Spouse Name: _____ __Married __Divorced __Single __Other
Address (if different):_____City:_____State:____Zip:_____
Home #: _____Cell #: _____Email address:_____
Employer: _____ SS#_____ Work#:_____

PRIMARY DENTAL INSURANCE
Policy Owner's Name: _____DOB: _____
ID #/Social Security #: _____Group/Policy #: _____
Dental Insurance Plan Name: _____
Claims Address:_____
Employer: _____
Insurance Co. Phone#:_____
Relationship to patient:_____

SECONDARY DENTAL INSURANCE
Policy Owner's Name: _____DOB: _____
ID #/Social Security #: _____Group/Policy #: _____
Employer: _____
Dental Insurance Plan Name: _____
Claims Address:_____
Insurance Co. Phone#:_____
Relationship to patient:_____

REFERRAL & PHARMACY INFORMATION
Whom may we thank for referring you to our office?

Referring Doctor/Office (Name): _____ Current Patient (Name): _____
Family Member (Name): _____

Drive By ____ Google _____ Website _____ Facebook _____ Newtown Athletic Club _____ Twitter _____
Health Fair _____ Facebook _____ St. Andrew's _____ Courier Times Website _____ Other _____

Pharmacy name:_____Phone #:_____
Emergency contact (not living with you) :_____Phone #:_____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that she/he is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient's examination. All fees associated with collections and/ or Attorneys cost will be your responsibility. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's needs. I grant permission to you or your assignee to telephone me at home and leave a messsage. I give my authorization to transfer any records or radiographs to another provider for treatment of my child. I understand that it is my responsibility to advise your office of any changes in the information contained in this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature:_____ Date: _____

New Patient Medical/Dental History Form
Newtown Dentistry for Adults

Patient Name: _____
Last First Initial Nickname Date of Birth

DENTAL HISTORY

Previous Dentist: _____ Phone: _____

Address: _____

Date of last dental care: _____ Date of last x-rays: _____

When do you brush your teeth? ☐ Upon arising ☐ After eating any food ☐ After meals ☐ Before going to bed

Do you eat between meals? ☐ Y ☐ N
Do you eat sweets (candy, soda pop, chewing gum)? ☐ Y ☐ N
Have you had cavities? ☐ Y ☐ N
Have you had any teeth removed by extraction? ☐ Y ☐ N
Was an appliance placed? ☐ Y ☐ N
Have there been any injuries to the teeth (falls, chips, blows)? ☐ Y ☐ N
If yes, explain _____

Have you had periodontal treatment? ☐ Y ☐ N
Have you ever received local anesthetic? ☐ Y ☐ N
Do you floss or use mouth rinses? ☐ Y ☐ N
Have you had any previous problems with dental treatment? ☐ Y ☐ N
If yes, explain _____

Do you think there is anything wrong with your teeth? ☐ Y ☐ N
If yes, explain _____

MEDICAL HISTORY

Physician's Name: _____ Phone: _____

Address: _____ Date of last visit: _____

Are you currently under a physician's care? ☐ Y ☐ N If yes, explain _____

Have you ever had any serious illnesses? ☐ Y ☐ N If yes, explain _____ Date _____

Have you ever had surgery? ☐ Y ☐ N If yes, explain _____ Date _____

Have you ever been hospitalized? ☐ Y ☐ N If yes, explain _____ Date _____

Please list any **MEDICATION(s)** you are currently taking:

_____

_____

Please list any **ALLERGIES** you have:

_____

_____

Have you had a history of any of the following?

- ☐ Acid reflux disease (GERD)
- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Asthma
- ☐ Autism
- ☐ Autoimmune Disease
- ☐ Cancer
- ☐ Cardiac Transplant
- ☐ Chemical/Alcohol Dependency
- ☐ Congenital heart defects
- ☐ Diabetes If yes what age? _____
- ☐ Dizziness
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Eyesight problems
- ☐ Fainting Spells
- ☐ Frequent headaches
- ☐ Hayfever
- ☐ Hearing loss
- ☐ Heart murmur
- ☐ Heart trouble
- ☐ Hepatitis
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpetic Lesions/Cold Sores
- ☐ HIV/AIDS
- ☐ Immunosuppression
- ☐ Kidney trouble (dialysis)
- ☐ Liver problems
- ☐ MRSA
- ☐ Psychiatric disorders
- ☐ Organ Transplants
- ☐ Prosthetic Replacement
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually Transmitted Diseases
- ☐ Severe/ prolonged bleeding
- ☐ Speech impairment
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Other _____

Additional comments: _____

I certify that the above information is complete and accurate.

_____ _____ _____ _____
Date Patient Signature Date Dentist Signature

Newtown Dentistry for Adults

CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct Michele L. Lefchack, D.M.D. and or dental auxiliaries of his/her choice to perform the following dental treatment or oral surgery procedures(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
B. Application of protective "sealants" to the grooves of the teeth.
C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
D. Removal (extraction) of one or more teeth.
E. Treatment of diseased or injured oral tissues (hard and/or soft).
F. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.

2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks/s will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor/s. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves and indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.

4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.

5. There are possible risks and complications associated with the administration of local anesthesia, sedation and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site) fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

6. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications, and case presentations.

7. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instructions of the dentist/s. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.

8. I hereby state that I have read and understand this consent and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

9. I further understand that this consent will remain in effect as long as I am a patient at Newtown Dentistry for Adults and **no treatment will be performed prior to authorization from parent or caregiver.**

Date: _____

Patient's name: _____

Signature: _____

Witness: _____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

Michele L. Lefchak, DMD
Newtown Dentistry for Adults LLC
46 Blacksmith Road Suite Tooth
Newtown, PA 18940

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.

_____ _____

Please ***print*** patient name Please ***sign***

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

□ Phone Message
□ Text Message
□ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____ _____

Signature of Privacy Officer