



Hello and a Heartfelt Welcome to Our Practice!

We appreciate the trust you have shown in us by selecting our office to care for your dental needs. We will make every effort to see that your dental visit is as comfortable as possible.

Your dental concerns come first with us. That is why we stay abreast of new dental techniques and continually improve our professional skills. Most importantly, we are sensitive to the feelings of our patients and encourage open communication.

On your first visit with us, you can expect a thorough oral examination including necessary X-rays. Please bring in your last set of Full Mouth X-rays. If they are not of diagnostic quality, or if they are more than three years old, we will take new ones. We will discuss with you how you can help prevent dental disease through good health habits, and do an oral cancer exam. We will listen carefully to your dental concerns and attempt to answer all of your questions thoroughly. Unless you have serious periodontal problems, we will schedule you to have a preventive prophylaxis or “teeth cleaning.”

Unless an emergency comes up, you can expect us to be on time. (We appreciate you being prompt also.) Please print out the new patient forms, fill them out at your convenience, and bring along to your first visit. If you have a dental insurance card, please bring that as well.

We look forward to meeting you! If you have any questions, please feel free to call us at (717) 259-9596.

Sincerely yours,

Lori Cockley, DDS
and The East Berlin Smiles Team



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____
Address: _____
Telephone: _____ Social Security # _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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 decide 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 protected health information, and of other important matters about your protected health information. 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 protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office at (717) 259-9596 or by mailing us at 418 West King Street, East Berlin, PA 17316.

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 address above. Please understand that revocation of this Consent will not affect any action we took before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

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 protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship: _____

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

418 West King Street • East Berlin, PA 17316 • (717) 259-9596

www.EastBerlinSmiles.com

EAST BERLIN *smiles* DENTAL CENTER

LORI COCKLEY, DDS, FAGD
(717) 259-9596
418 West King Street
East Berlin, PA 17316
www.EastBerlinSmiles.com

Your complete oral health is our main concern. Communication is key to helping us give you a happy, healthy smile. We therefore ask that you complete this form in its entirety.

1 ABOUT YOU

Today's Date: _____
E-mail Address: _____
Name: _____
LAST FIRST MI MR MRS MS DR
I prefer to be called: _____ Male Female
Birthdate: ___/___/___ Age: _____ SS #: _____
Home Address: _____
APT / CONDO #

CITY STATE ZIP
 Single Married Divorced Widowed Separated
Home #: (____) _____ Pager/Cell #: (____) _____
Do you receive text messages? Yes No
Work #: (____) _____ Ext: _____ DL #: _____
Employer: _____
Employer's Address: _____
How long there? _____ Occupation: _____
Where and when are best times to reach you? _____
Whom may we thank for referring you? _____
Other family members seen by us: _____
Previous/Present Dentist: _____
(please circle)
Last Visit Date: _____

2 SPOUSE INFORMATION

Name: _____
Employer: _____
Work #: (____) _____ Ext: _____ SS #: _____
Birthdate: ___/___/___ DL #: _____

Person Responsible for Account:

Work #: (____) _____ Ext: _____ Home #: (____) _____
Billing Address: _____
Relation: _____ SS #: _____
Employer: _____ DL #: _____

3 DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: (____) _____
Group # (Plan, Local or Policy #): _____
Insured's Name: _____ Relation: _____
Insured's Birthdate: ___/___/___ Insured's ID #: _____
Insured's Employer: _____
Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: (____) _____
Group # (Plan, Local or Policy #): _____
Insured's Name: _____ Relation: _____
Insured's Birthdate: ___/___/___ Insured's ID #: _____
Insured's Employer: _____
Employer's Address: _____

In the event of an emergency, is there someone that we should contact?

Name: _____ Relation: _____
Work #: (____) _____ Home #: (____) _____

4 MEDICAL HISTORY

Do you have a personal physician? Yes No
Physician's Name: _____
Phone #: (____) _____ Date of last visit: _____
Are you currently under the care of a physician? Yes No
Please Explain: _____

CONTINUED ON NEXT PAGE

4 MEDICAL HISTORY *continued*

Your current physical health is: Good Fair Poor
Are you taking any prescription, over-the-counter, or supplement drugs?
 Yes No

Please list each one: _____

Do you smoke? Yes No

Do you use smokeless tobacco? Yes No

Have you ever taken Fosamax, Actonel, Boniva, or any other bisphosphonate? Yes No

Are you using an oral contraceptive (birth control pills)? Yes No

Are you pregnant? Yes No Due date _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems? (Please circle option that applies)

Y N Artificial Bones/Joints/Valves	Y N Hemophilia/Abnormal Bleeding
Y N Asthma	Y N Hepatitis
Y N Cancer/Chemotherapy	Y N High/Low Blood Pressure
Y N Congenital Heart Defect	Y N HIV+/AIDS
Y N Diabetes	Y N Hospitalized for Any Reason
Y N Difficulty Breathing	Y N Kidney Problems
Y N Drug/Alcohol Abuse	Y N Mitral Valve Prolapse
Y N Epilepsy/Seizures/Fainting Spells	Y N Psychiatric Problems
Y N Fever Blisters/Herpes	Y N Rheumatic/Scarlet Fever
Y N Heart Attack/Stroke	Y N Severe/Frequent Headaches
Y N Heart Murmur	Y N Sickle Cell Disease/Traits
Y N Heart Surgery/Pacemaker	Y N Sinus Problems

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following?

Y N Aspirin	Y N Dental Anesthetics	Y N Latex
Y N Codeine	Y N Jewelry/Metals	Y N Penicillin

Please list any other drugs/materials that you are allergic to: _____

5 DENTAL HISTORY

Why have you come to the dentist today?

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes No

Your current dental health is: Good Fair Poor

Do your gums ever bleed? Yes No

Have you ever been diagnosed with gum disease or treated for gum disease? Yes No

How many times per day do you brush? _____

How many times per week do you floss? _____

Do you use a manual toothbrush or an electric toothbrush? _____

I understand the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. My signature indicates I have received a copy of the HIPAA law and Dental Materials forms and release East Berlin Smiles to use any dental photographs or videos for lecturing, promotional, or educational purposes.

Signature _____

Date _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

We appreciate your effort to fill out this complete form. It will ensure that we can provide the most effective care possible. Please do not hesitate to ask if you have any questions. We are here for you.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

Smile Evaluation

Are you delighted with your smile? _____ Please rate your smile from 1 to 10 (1 = I dislike my smile, 10 = awesome) _____

Would you like to have whiter teeth? _____ Yes _____ No

If you had a magic wand, what, if anything, would you change about your smile? _____

How healthy would you like us to get your mouth? (Please circle one.)

The best it can be

Average

My dental health is not a big priority for me

Should you need treatment, at what point would you like us to address it? (Please circle one.)

When it isn't ideal

When it is worsening

Only when it hurts or breaks

What caused you to leave your last dental office? _____

What do you already know about us and what made you choose our office? _____



FINANCIAL MENU

We consider our relationship with you to be of primary importance and will always make our recommendations based on what we believe is the very best treatment for you, regardless of your insurance coverage or financial arrangements. For your comfort and convenience, we offer a wide range of financial options and welcome your suggestions and questions.

A) Split Payment (For treatment over \$1000)

Half of the total payment is due when appointment is reserved, and the second half is due at preparation visit of the crown/bridges/veneers, etc.

B) Payment Plans

Pay for treatment over 6 to 12 months with no interest or low fixed rates on extended payment plans. Feel free to contact our office for specific details.

C) Prepayment in Full (For treatment over \$1000)

A prepayment Bookkeeping Courtesy of 5% will be given for direct payment in full by cash, check, or credit card two business days before the first treatment visit.

Patients with dental benefits: Your dental benefits are based upon a contract made between your employer and an employee benefits company. If you have any questions regarding your dental benefits, please contact your employer or the benefits carrier directly.

We will submit your claim to your insurance company as a courtesy, as we do not participate with any insurance company. Our office does request payment in full for your estimated portion at the time of service. All outstanding insurance claims are closed 30 days after date of service and any remaining balance is billed to you at the time. If you have dental insurance through Delta and United Concordia, payment in full is collected at the time of service, as your insurance company mails the check directly to you.

Appointment Policy: We value your time and reserve the appointment time especially for you. Therefore, we kindly request 48 hours notice if you are unable to keep your appointment. If notice is not given, a missed appointment fee may be assessed.

Collections: I understand that if I become delinquent on my account, my account will be turned over to a collections agency, and a 35% collection fee will be added to the delinquent balance.

FORMS OF PAYMENT ON BALANCES DUE

In order to facilitate access to the very best health care possible, you may choose from any of the following: Cash, Visa, MasterCard, Discover, Money Order, Payment Plan or Personal Check. (A fee of \$30.00 is added to all returned checks.)

I understand that if I become delinquent on my account, my account will be turned over to a collection agency, and I will subsequently be reported to the credit bureaus. In case of total default, I promise to pay any collection costs and attorney fees incurred to collect on this account.

I certify that I have read, fully understand, and accept the above financial policy.

Signature: _____ Date: _____

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EAST BERLIN
smiles
DENTAL CENTER

COMFORT MENU

Your comfort is our priority. We provide a variety of services to ensure that you are comfortable at all times. Please select from the following options:

- Patients find that if they take an analgesic prior to treatment it helps later in the day.
Which would you prefer? Tylenol Advil Other _____
- We provide various levels of sedation to ease your mind.
Would you like to discuss the use of a prescribed oral sedative to help ease your mind?Yes No
(With this sedative, you must have someone else drive you to and from your appointment.)
- Blankets help keep you warm and relaxed through your visit.
Would you like a blanket?.....Yes No
- Heated neck wraps keep you comfortable and warm through your visit.
Would you like a neck wrap?.....Yes No
- Pillows provide an extra measure of comfort if you have a sore back or neck.
Would you like a pillow?.....Yes No
- We offer a complimentary hand paraffin wax treatment to relax you during your visit.
Would you like to take advantage of this service?.....Yes No
- We provide headphones and MP3 players for your listening pleasure.
Would you like to listen to a MP3 player?..... Yes No
- Is there anything else we can do for you to make your visit comfortable?

Please place a check mark in the box next to the statements that concern you or describe your problem.

- I gag easily.
- I feel out of control when I'm lying down in the dental chair.
- I have not been to the dentist for a long time, and I feel uncomfortable about what you will say about my teeth and my dental hygiene.
- Pain relief is a top priority for me.
- I don't like shots (or I've had a bad reaction to shots).
- Please tell me what I need to know about my mouth in order to make an informed decision. I like to have as much information as possible.
- My teeth are very sensitive.
- I don't like the sound of that tool that makes the picking and scraping noise. It is like someone is scratching fingernails on a blackboard.
- I don't like cotton in my mouth.
- I hate the noise of the drill.
- Please respect my time. I don't want to be left sitting in the reception area.
- I want to know the cost up front. No money surprises please.
- I have difficulty listening and remembering what I hear while sitting in the dental chair.
- I have health problems and questions that we need to discuss.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples would be teeth cleaning services, extraction letters, and periodontal or endodontic referrals.
- *Payment* means such activities as obtaining reimbursement for services, confirming coverage, and obtaining specific benefit information such as benefit maximums and deductibles met, etc., billing or collection activities, and utilization review.
- *Health care operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain—and we have the obligation to provide—a paper copy of this notice from us at your first delivery of services date.
- The right to provide—and we are obligated to receive—a written acknowledgement that you have received a copy of our Notice of Privacy Protection Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health.

This notice is effective as of April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that our privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of their provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

East Berlin Smiles Dental Center
418 West King Street
East Berlin, PA 17316
(717) 259-9596
www.EastBerlinSmiles.com

For more information about HIPAA or to file a complaint:

The U. S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
202-619-0257
Toll Free: 1-877-696-6775