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Pi Dental Center
467 Pennsylvania Avenue
Fort Washington, PA 19034 USA
(215) 646-6334 Office
piteam@pidentalcenter.com

Today's Date _____

Pharmacy Name _____

Pharmacy Phone _____

Confidential Medical and Dental History Record

PATIENT INFORMATION

Name _____ I prefer to be addressed in person as _____

Date of Birth _____ Social Security Number _____ Marital Status: Married ☐ Spouse's Name _____ Single ☐

Email Address _____

Home Address _____

Cell Phone (___) _____

Home Phone (___) _____

Occupation _____

Employer _____

Work Phone (___) _____

Address _____

Name of Emergency contact person _____ Relationship _____

Cell (___) _____ Other (___) _____

Personal Physician Name _____ General Dentist Name _____

Phone (___) _____ Phone (___) _____

Address _____ Address _____

Where did you learn about us? (Check All That Apply)

☐ Internet ☐ Radio
☐ Magazine ☐ Television
☐ My Dentist _____
☐ Other _____

Can we thank someone for referring you to Pi Dental Center?
Name _____

What has prompted your visit to Pi Dental Center today? _____

INSURANCE INFORMATION

Do you have dental insurance? Yes ☐ No ☐

Primary Dental Insurance Company _____

Name of Policy Holder _____

Policy Holder's Date of Birth _____

Group Plan Name _____

Name of Policy Holder's Employer _____

Do you have Medicare? Yes ☐ No ☐

Address _____

Relationship of Policy Holder to You _____

Policy Holder's SS# _____

Group Plan Number _____

Employer's Address _____

Secondary Dental Insurance Company _____

Name of Policy Holder _____

Policy Holder's Date of Birth _____

Group Plan Name _____

Name of Policy Holder's Employer _____

Address _____

Relationship of Policy Holder to You _____

Policy Holder's SS# _____

Group Plan Number _____

Employer's Address _____

MEDICAL HISTORY

1. Are you now under the care of a physician? Yes ☐ No ☐
   If yes, treating doctor? _____ Condition? _____
2. Have you ever had any serious illness or operation? Yes ☐ No ☐
   If yes, what illness or operation? _____ Date _____ Doctor _____
3. Do you have any known allergies? Yes ☐ No ☐ Please List Them _____
4. Do you use any tobacco products? Yes ☐ No ☐ Please describe ☐ Cigarette ☐ Pipe ☐ Cigar ☐ Chewing Tobacco ☐ Vape
   Quantity _____ Years _____ Currently _____ In the past _____ How long since last used? _____
5. Do you drink soda? Yes ☐ No ☐ If so, how much? _____ Per Day _____
6. (Women) Are you pregnant? Yes ☐ No ☐
7. Are you taking or scheduled to begin taking an antiresorptive agent (Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia etc) Yes ☐ No ☐

8. Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (Aredia, Zomenta, XGEVA etc.) for bone pain, Hypercalcemia or skeletal complications resulting from Paget's Disease, Multiple Myeloma or Metastatic Cancer? Yes ☐ No ☐

9. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes ☐ No ☐

List medications that you are taking

Check	Name of Medication	Reason for Use	# Per Day	Dosage	# of Years Taken	Prescribing Doctor
☐						
☐						
☐						
☐						

Do You Currently Have Or Have You Had Any Of The Following Conditions? Check All That Apply.

Conditions	Conditions	Conditions
☐ Congestive Heart Failure	☐ Epilepsy/Seizures	☐ Prosthetic Joint Replacement
☐ AIDS/ HIV Positive	☐ Fainting Spells	☐ Psychiatric /Nervous Disorder
☐ Arteriosclerosis	☐ Fever Blisters	☐ Ulcers
☐ Heart Murmur	☐ Frequent Headaches	☐ Respiratory Disease
☐ Alzheimer's Disease	☐ Head Injuries	☐ Rheumatism
☐ Anorexia Or Bulimia	☐ Hepatitis, Liver Disease (A/B/C)	☐ Sinus Trouble
☐ Arthritis	☐ High Blood Pressure	☐ Gastrointestinal Disorders
☐ Blood Disorders	☐ Intestinal Disease	☐ Stroke
☐ Burning Tongue	☐ Kidney Problems/Disease/Dialysis	☐ Thyroid or Parathyroid Disease
☐ Cancer	☐ Leukemia	☐ Tumors or Growth
☐ Heart Attack	☐ Lung Disease	☐ Xerostomia (Dry Mouth)
☐ Diabetes	☐ Mitral Valve Prolapse	☐ Sleep Problems
☐ Drug Dependency	☐ Osteoporosis Or Osteopenia	☐ Other _____

DENTAL HISTORY

1. Have you ever had an unfavorable reaction to a local anesthetic? Yes ☐ No ☐
2. How long since your last dental x-ray? _____
3. How long since your last dental treatment? _____
4. Have you ever had general anesthesia for medical / dental treatment? Yes ☐ No ☐ When? _____

CONSENT FOR TREATMENT

I hereby authorize any treatment necessary as related to the dental care of the patient whose name appears on this health history form and grant authority to administer such anesthetics, analgesics, sedatives and nitrous oxide sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I understand that there are possible adverse effects of the procedures, anesthetics and/or drugs to be employed.

- I consent to photographs, recording, and x-rays of my oral and facial structures and their publication and the observation by additional professional staff for educational and scientific purposes only. My name will not be revealed without my consent.
- I am aware that Pi Dental Center is NOT a Participating Provider with any dental, medical, or health insurance company, including Medicare and Medicaid.
- Although Pi Dental Center does not accept insurance for its services and treatment, Pi Dental Center may submit a claim to my insurance company on my behalf at my request, in an effort to assist in obtaining insurance reimbursement directly to me. Pi does not submit claims to Medicare or Medicaid. It is understood that even with this courtesy, it is my responsibility to pay for all financial aspects of any services and treatment I receive.
- I understand that I am responsible for payment of any outstanding balance and any delinquent account will be turned over to a professional collection agency.
- I am aware that failure to provide at least 48 hours' notice of appointment cancellation will result in a cancellation fee.

Signature of Patient or Guarantor _____ Date _____

Medicare Opt-Out Private Contract

This contract between Prosthodontics Intermedica ("Dentist") and _____ (Medicare beneficiary, referred to in this contract as "Patient") allows Dentist to provide treatment to Patient without being subject to Medicare limits. To do so, the law requires Dentist to "opt out" of Medicare and that no Medicare claim be filed for the treatment of Patient by Dentist.

Dentist represents that Dentist is excluded from participation under the Medicare program under §1128, 1156 or 1892 of the Social Security Act; in addition, Patient and Dentist agree that Patient is not now facing an emergency or urgent health care situation.

By signing this contract, Patient does the following:

(i) Agrees not to submit a Medicare claim (or to request that Dentist submit a claim) for services or items supplied by Dentist, even if they are otherwise covered under Medicare;

(ii) Agrees to be responsible, whether through insurance or otherwise, for payment of services or items supplied by Dentist, and understands that no reimbursement will be provided under Medicare for those services or items; in particular, Patient will pay for such services at Dentist's usual and customary rate, in a accordance with Dentist's payment policies;

(iii) acknowledges that Medicare limits do not apply to amounts that Dentist may charge for such services or items;

(iv) Acknowledges that Medigap plans do not, and other supplemental insurance may elect not to, make payments for items and services covered by this contract, because payment is not made under Medicare; and

(v) Acknowledges that Patient has the right to have such services or items provided by other dentists or practitioners for whom payment would be made under Medicare.

This contract shall remain in force and effect from the date it is signed by Patient until the end of the term of the Dentist's current opt-out period.

Accepted and Agreed: _____
Dentist

Signature Accepted and Agreed: _____
Patient or Patient's Legal Representative

Private Contract Agreement

This contract between Prosthodontics Intermedica ("Dentist") and _____ (Insurance beneficiary, referred to in this contract as "Patient") allows Dentist to provide treatment to Patient without being subject to insurance limits.

By signing this contract, Patient does the following:

(i) Agrees to be responsible, whether through insurance or otherwise, for payment of services or items supplied by Dentist; in particular, Patient will pay for such services at Dentist's usual rate (or any other agreed upon rate), in accordance with Dentist's payment policies;

(ii) Acknowledges that insurance limits do not apply to amounts that Dentist may charge for such services or items;

(iii) Acknowledges that supplemental insurance may elect not to make payments for items and services covered by this contract

(iv) Acknowledges that Patient has the right to have such services or items provided by other dentists or practitioners for whom payment would be made under Patient's insurance.

(v) Acknowledges that Pi Dental Center does not accept, submit or prepare medical claims.

This contract shall remain in force and effect indefinitely from the date it is signed by Patient.

Accepted and Agreed: _____

Dentist

Accepted and Agreed (Signature): _____

Patient or Patient's Legal Representative

Pi Dental Center

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES
CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

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

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA?

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND 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
☐ Text Message to my Cell Phone
☐ Home Phone Confirmation
☐ Email Confirmation
☐ Work Phone Confirmation
☐ **Any of the Above**

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

☐ Cell Phone Confirmation
☐ Text Message to my Cell Phone
☐ Home Phone Confirmation
☐ Email Confirmation
☐ Work Phone 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.

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 / FACILITIES IN THE FUTURE.**

_____ _____
Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

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_____ *Revised, Jan 2019*

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Glenn J. Wolfinger, DMD, FACP, Board Certified Prosthodontist