Po Dentistry
1661 Manheim Pike Suite A, Lancaster, PA 17601
(717) 569-7319
www.podentistry.com/

NEW PATIENT FORM

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
SSN #:		Marital status:	
Referral source:		Employer:	
Referred by:		Occupation:	

Contact Information

Mobile phone:	
Home phone:	
Email:	

Address Information

Street address:	
City:	
State:	
ZIP:	

Emergency Contact

Full Name:	
Phone number:	
Relation:	

Work Information

Street address:	
City:	
State:	
ZIP:	

Patient's signature:

Date:

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HEALTH HISTORY

| DOB:

Summary

Medical Conditions	
Allergies	
Medications	

General Health Information

Are you currently under the care of a physician?	
Physician phone number	
Date of last physical exam	
Are you presently being treated for any injury or illness?	
Have you ever been hospitalized for an injury or illness?	
Are you pregnant or planning to become pregnant?	
Are you currently breastfeeding?	
Are you required to pre-med with antibiotics before dental treatment?	
Do you use alcohol?	
Do you use or have you ever used tobacco?	
Have you ever had an allergic reaction?	

Medical Conditions

Please check all conditions that you have history of or are currently being treated for	
Do you have a history or are currently being treated for any Digestive conditions?	
Do you have a history or are currently being treated for any Heart or Circulatory conditions?	
Do you have a history or are currently being treated for any Neurological conditions?	
Do you have a history or are currently being treated for any Lung or Breathing conditions?	
Do you have a history or are currently being treated for any Autoimmune conditions?	
Head or neck injuries?	
Artificial Joint?	
High cholesterol?	
History of cancer?	
Tumor or abnormal growth?	
Radiation therapy?	
Chemotherapy?	
HIV / AIDS?	
Osteoporosis / osteopenia?	
Type I or Type II diabetes?	
Anemia?	

Kidney disease?	
Liver disease?	
Thyroid disease?	
Tuberculosis / measles / chicken pox?	
Any other medical condition we should know of?	

Medications

Please check all medications you are currently taking	
Are you taking any pain medications?	
Are you taking any Antidepressants or Anxiety medications?	
Are you taking any Diabetes, Cholesterol, or Blood Pressure medications?	
Are you taking any Allergy or Asthma medications?	
Are you taking any Antibiotics?	
Are you currently taking any other medications or dietary supplements?	

Patient's signature: Date:

Doctor's signature: Date:

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DENTAL HISTORY

| DOB:

General Information

Who was your previous Dentist and how long were you a patient there?	
Date of your last dental exam	
Date of your last cleaning	
Do you have any immediate concerns you'd like us to address?	

Office Relationship

What do you value most in your dental visits?	
Is there anything you prefer during your visits to make you more comfortable during your time with us?	
On a scale from 1-5, 5 being most terrified, are you fearful of dental treatment?	

Personal History

Please answer the following questions	
Are you concerned about the appearance of your teeth?	
Are you interested in improving your smile?	
Have you had any cavities within the past 2 years?	
Are any teeth currently sensitive to biting, sweets, hot, or cold?	
Do you avoid or have difficulty chewing or biting heavily any hard foods?	
Do you have any problems sleeping, wake up with a headache or with sore or sensitive teeth?	
Do you clench your teeth in the daytime?	
Do you wear, or have you ever worn a bite appliance? Either for clenching at night (a night guard) or for sleep apnea?	
Do you bite your nails, chew gum or on pens, hold nails with your teeth, or any other oral habits?	
Does the amount of saliva in your mouth seem too little or do you find yourself with a dry mouth often?	
Have you ever noticed a consistently unpleasant taste or odor in your mouth?	

Dental Structural History

Please answer the following questions	
Do your gums bleed when brushing or flossing?	
Is brushing or flossing typically painful?	
Have you ever experienced or been told you have gum recession?	
Have you ever been treated for or been told you have gum disease?	
Have you had any teeth removed for braces or otherwise?	
Do you know of any missing teeth or teeth that have never developed?	
Have you ever had braces, orthodontic treatment or spacers, or had a "bite adjustment?"	

Are your teeth becoming more crowded, overlapped, or "crooked?"	
Are your teeth developing spaces?	
Do you frequently get food caught between any teeth?	
Have you noticed your teeth becoming shorter, thinner, or flatter over the years?	
Do you have problems with your jaw joint? (TMD, popping, clicking, deviating from side to side when opening or closing?)	
Is it often difficult to open wide?	
Do you have more than one bite? Or do you notice shifting your jaw around to make your teeth fit together?	

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Doctor's signature: Date:

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DENTAL INSURANCE INFORMATION

| DOB:

Created at: **08/02/2024 3:45:24 PM**

Primary Insurance Information

Do you have a dental insurance?	
Would you like to upload insurance card photo?	
Patient's relationship to the Insurance Holder	
Policy Holder's Name	
Policy Holder's Date of Birth	
Policy Holder's SSN	
Policy Holder's Address	
Policy Holder's City	
Policy Holder's State	
Policy Holder's ZIP	
Policy Holder's Phone Number	
Policy Holder's Employer	
Dental Insurance Company	
ID Number	
Group Number	
Phone number on the back of your insurance card	
Address on the back of your insurance card	

Secondary Insurance Information

Do you have a secondary dental insurance?	
That's all! If you would like to add secondary insurance, you need to provide primary insurance first.	
Would you like to upload insurance card photo?	
Patient's relationship to the Insurance Holder	
Policy Holder's Name	
Policy Holder's Date of Birth	
Policy Holder's SSN	
Policy Holder's Address	
Policy Holder's City	
Policy Holder's State	
Policy Holder's ZIP	
Policy Holder's Phone Number	
Policy Holder's Employer	
Dental Insurance Company	
ID Number	
Group Number	

Phone number on the back of your insurance card	
Address on the back of your insurance card	

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CONSENT FOR GENERAL DENTISTRY

| DOB:

Informed Consent Information

- **Examination and X-Rays**
  I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.
- **Local Anesthesia**
  Anesthetizing agents are injected into a small area or injected as a nerve block directly into a larger area of the mouth with the intent of numbing the area to receive dental treatment. Risks include but are not limited to infection, swelling, allergic reactions, hematoma, bruising, discoloration, headache, tenderness at the needle site, dizziness, nausea, vomiting, and cheek/tongue/lip biting can occur from the injection. It is normal for the numbness to take time to wear off after treatment, usually 2-3 hours. However, it can take longer, and rarely the numbness is permanent if the nerve is injured.
- **Drugs, Medications & Sedation**
  I have been informed and understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and/or a lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for **at least 12 hours or until fully recovered** from the effects of the anesthetic medication and drugs that may have been given to me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may increase risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.
- **Changes in Treatment Plan**
  I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on my teeth that were not discovered during the examination. The most common being root canal therapy following routine restorative procedures. I give my permission to Doctor to make any changes and additions as necessary.
- **Temporomandibular Joint Dysfunctions (TMJ)**
  I understand that symptoms of popping, clicking, locking, and pain can intensify or develop in the joints of the lower jaw(near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well-tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.
- **Fillings**
  I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage, and tooth sensitivity is a common after-effect of newly placed fillings.
- **Removal of Teeth (Extraction)**
  I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue(paraesthesia) that can last for an indefinite period of time or a fractured jaw. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment. The cost of which is my responsibility.
- **Crowns, Bridges, Veneers, and Bonding**
  I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily, and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes to my new crown, bridge, or cap(including shape, fit, size, placement, and

color) will be done before cementation after which additional fees may apply. It has been explained to me that in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

- **Dentures - Complete or Partial**
  I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including but not limited to looseness, soreness, and possible breakage. I realize that the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be a "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement and the cost of relining is not included in the initial denture fee.
- **Endodontic Treatment (Root Canal)**
  I realize there is no guarantee that root canal treatment will save my tooth. I realize that complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment(apicoectomy).
- **Periodontal Treatment**
  I understand periodontitis(gum disease) is a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I understand the success of treatment depends in part on my efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products, and follow other recommendations.

CONSENT

I understand that the doctor is not responsible for previous dental treatment. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that no guarantees of results or absolute satisfaction are possible with dental treatment. I have truthfully answered all questions about my medical history and present health condition fully and truthfully. I have told Doctor or other office personnel about all conditions, including allergies, which might indicate that I should receive oral medications and/or anti-anxiety agents. I will not hold Doctor or associates responsible for any errors or omissions I may have made. I also understand if I ever have any changes in health status or in medication(s), I need to inform the doctor at the next appointment. I authorize Doctor to forward a review of findings and/or any other necessary dental information to the referring doctor for his/her records, as well as any third parties such as insurance companies who may request information. I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All of my questions have been answered by Doctor in a satisfactory manner and I believe I have all of the necessary information to give informed consent for treatment. I further understand that this consent shall remain in effect until terminated by me.

Patient's signature: Date:

Doctor's signature: Date:

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PRIVACY POLICY CONSENT

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (HIPAA).

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 1661 Manheim Pike Suite A, Lancaster, PA 17601:

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as Psychotherapy Notes. All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separately from the rest of the clients medical records to maintain a higher standard of protection. Psychotherapy Notes are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individuals medical records. Excluded from the Psychotherapy Notes definition are the following: (a) medication prescription and

monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release Psychotherapy Notes to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individuals dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient's signature: Date:

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FINANCIAL POLICY

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are 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.

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.

UNPAID BALANCE over 90 days old will be subject to a monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorneys fees, and court costs associated with the recovery of the monies due on the account.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation 48 hours in advance, you will be charged a fee of $75 - $150, depending on the amount of time reserved for your appointment. Please help us maintain the highest quality of care by

keeping scheduled appointments.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient's signature: Date:

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HIPAA – RELEASE OF INFORMATION AUTHORIZATION FORM

| DOB:

HIPAA - RELEASE OF INFORMATION AUTHORIZATION FORM

In compliance with federal and state law, the release of information for any person 18 years or older (including the information regarding a spouse or adult child), **must first be authorized**. Authorization includes the signature of the individual authorizing the release of their information. Information **will not be available** to anyone other than the covered patient (i.e. a member, a spouse, or any dependent age 18 or older) without first having this Release of Information Authorization on file. For example, if a subscriber calls about the status for a claim on a 19-year old dependent, that information will not be given to the subscriber without the written consent of the dependent. The same situation holds true for spouse-to-spouse information. However, parents do have a right to information on children under the age of 18 without the childs consent.

I want to provide the authorization	

Information Regarding Person Authorizing Releasing His/Her Information

Name of person authorizing release	
Date of Birth person authorizing release	
Personal Information to be released	
The above information may be released and/or received by	

The following is an authorization allowing Po Dentistry to release information to whomever you designate. Po Dentistry is authorized to make the disclosure of my benefits information, claim(s) status, claim(s) history, general claim information, dentist information, lab cases, and enrollment information, unless otherwise specified to the following individual(s) or organization(s):

Name of person/organization that the office may release my information to	
Relation of person/organization that the office may release information to	
Phone number of person/organization that the office may release information to	
I want to add a second person/organization	
Name of person/organization that the office may release my information to	
Relation of person/organization that the office may release information to	
Phone number of person/organization that the office may release information to	
I want to add a third person/organization	
Name of person/organization that the office may release my information to	
Relation of person/organization that the office may release information to	
Phone number of person/organization that the office may release information to	
I want this consent to	

AUTHORIZATION CONSENT

I understand that consent may be revoked by me at any time in writing. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practices Notice of Privacy Practices.

Patient's signature: Date:

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COMMUNICATION CONSENTS

EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Po Dentistry offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Po Dentistry will use reasonable means to protect the security and confidentiality of email information sent and received. However, Po Dentistry cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Po Dentistry and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Po Dentistry.

Patient's signature: Date:

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TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Po Dentistry, offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Po Dentistry will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Po Dentistry cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Po Dentistry and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Po Dentistry.

Patient's signature: Date:

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DEBIT/CREDIT CARD PAYMENT AUTHORIZATION FORM

| DOB:

Please complete the following information to authorize the use of your credit card for payment at Po Dentistry.

Full Name of Cardholder:	
Card Type:	
Last 4 Digits of Credit/Debit Card:	
Card Expiry Date:	

Billing Address:

Street Address:	
City:	
State:	
Zip Code:	

Terms and Conditions:

1. This authorization is valid for the current treatment session and any additional sessions as agreed upon.
2. The cardholder will receive a receipt for all charges made.
3. Any cancellations or changes to scheduled appointments must be made in accordance with our practice's policies.
4. The cardholder is responsible for ensuring sufficient funds are available for payment.
5. In the event of a dispute, please contact Po Dentistry immediately.

Security and Privacy:

We take the security of your personal information seriously. All credit card information provided will be kept confidential and securely stored in compliance with industry standards.

Contact Information:

For any questions or concerns regarding this form, please contact us at:

Po Dentistry (717) 569-7319 jenpodmd@yahoo.com

Authorization:

I, the undersigned, authorize Po Dentistry to charge my credit card for the agreed-upon services and amounts. I confirm that the information provided is accurate.

Patient's signature: Date: