DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No	Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Chew on one side of mouth	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
			Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
			Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
			Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
			Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
			Foreign objects	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
			Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
			Gums swollen or tender	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No
			Jaw pain or tiredness	☐ Yes	☐ No	How often do you floss? _____		
			Lip or cheek biting	☐ Yes	☐ No			
			Loose teeth or broken fillings	☐ Yes	☐ No	How often do you brush? _____		

5 HEALTH HISTORY

Physician's Name _____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
			High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No			
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name_____

Phone (_____) _____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other_____

☐ Latex _____

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what?_____

Patient's Signature _____ Date_____

Doctor's Signature _____ Date_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what?_____

Patient's Signature _____ Date_____

Doctor's Signature _____ Date_____

Barry E. Yelk D.M.D., P. C.

General and Cosmetic Dentistry

1569 Medical Drive, Suite 102

Pottstown, PA 19464

Phone: (610)326-2772 Fax (610)326-2509

Email: drbarryyelk@yahoo.com

AUTHORIZATION TO RECEIVE PAYMENT FOR SERVICES AND TO RELEASE OR RECEIVE WRITTEN/VERBAL INFORMATION

It is necessary to obtain payment for our services from second or third party payers. In order to provide dental treatment and to receive payment for our services it is necessary to exchange information with your insurance company. It may also be necessary to send or receive information from other professionals or agencies in the course of your dental treatment. Any information received will become part of your clinical record. Information received from other sources cannot be released by the office.

*Before we exchange information we need your written authorization.

Patient's name_____
Social Security number_____/_____/_____
Birth date _____/_____/_____

I hereby authorize this office to send or receive the information checked below:

☐ X-rays
☐ Treatment evaluation
☐ Dental treatment statements for evaluation to any and all related agencies, specialists, and/or insurance companies.

I have been informed that I may revoke this permission at anytime by writing to the office. Consequently, I understand that if revoked, Dr. Yelk will no longer continue to provide dental treatment.

I have read and understand the content of this document and understand that a fax copy or a photo copy shall be considered as the original.

This authorization will expire (2) year(s) from this date _____/_____/_____

Circle the relationship to below and sign
Signature of Patient / Parent / Guardian

Print Name _____ Date __/__/__
Witness _____ Date __/__/__

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Appointments

A minimum charge will be made for failed or canceled appointments without prior notification of 48 business hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc. Once an appointment is made, please remember this time has been reserved for you.

Insurance

To avoid any misunderstanding, we wish patients to know that payment of fees is the personal responsibility of the patient. We will prepare any necessary forms or reports and submit them to your primary insurance company to help you obtain your benefits. We do not render our services on the basis that insurance companies will pay all of our fees. Each fee is individual for the individual patient.

Finance Charge

Failure to make payment on a monthly statement will generate a finance charge (18% annual percentage rate).

Fillings

Only composite fillings (tooth colored) are used in this office. However, some insurance companies will only pay for comparable silver (amalgam) fillings. In this case, it is the patient's responsibility to pay the difference.

Signature_____ Date _____

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Most dental insurance policies have a yearly benefit ($) maximum .

Our office does not track the treatment you require in relation to your policy maximum. If you exceed your maximum, you will be responsible for any treatment not covered.

To prevent any unwanted expense, we recommend you stay in contact with your Insurance Company throughout your treatment.

Signature_____ Date_____

Notice of Privacy Practices

This notices describes how medical information about you may be 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 weather 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 insurance information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this brief explanation of how we are required to maintain the privacy of your health information, and how we may use and disclose such information.
We may use and disclose your medical records only for each of the following purpose: Treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would teeth cleaning services.
Payments meaning such activities as obtaining reimbursements for services, confirming coverage, billing, or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
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. We may also distribute de identified health information by removing all references to individually identifiable information
Appointment reminders and follow up. We may contact you to provide appointment reminders, information about treatment alternatives, or other health related services or benefits that may be of interest to you.
Business associates We may provide information to out side parties so they can perform certain functions or services on our behalf. Each Business associate must sign a contract with us before we send him or her any information. That contract requires them to protect the confidentiality of your medical information.
Treatment alternatives. We may discuss medical information to tell you about and recommend treatment alternatives that may be of interest to you.
Health Related Benefits and services We may use and disclose medical information to tell you about health related benefits or services that may be of interest to you.
We will disclose Medical information about you when required to do so by state, local, or federal Law.
To avert a Serious threat to health or safety We may use and disclose information about you when necessary to prevent a serious threat to your health and safety or that of another person.
Organ and Tissue Donation If you are an organ donor or potential recipient, we may release information to organ procurement organization as necessary to facilitate organ transplantation or donation.
Military and veterans. If you are a member of the armed forces, we may release Dental/Medical information about you as required by military command authorities.
Workers Compensation. We may release Dental/Medical information about you for workers compensation or similar programs.
Public Health Risks. We may disclose Dental/Medical information about you for public health activities. These activities may include: the prevention or control of disease, reports of births and deaths, reports of child abuse or neglect notify people of recalls and to report medication reactions.
Health Oversight Activities. We mat Disclose Dental/Medical l information to health oversight agencies for activities required by law. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
Judicial proceedings. We may disclose Dental/Medical information about you in response to a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request, or other lawful process by someone else after reasonable efforts to notify you or obtain a protective order.
Law Enforcement.. We may disclose Dental/Medical information if asked to do so by a law enforcement official, to identify or locate a suspect, witness or missing person, or a victim of a crime (with your consent

in certain circumstances), report deaths from criminal conduct, crimes on the premises, or in emergencies to report a crime.

Coroners medical Examiners and Funeral Directors. We may release Dental/Medical information to the aforementioned people in order to identify a deceased person, determine cause of death of as reasonably necessary to carry out their duties.

Inmates If you are an inmate of a correctional institution, we may release medical information about you to the correctional institution or to law enforcement officials.

YOU HAVE THE FOLLOWING RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Right to inspect and copy. You have the right to inspect and copy Dental/Medical information that may be used to make decisions about your care.

To inspect and copy information that may be used to make decisions about your treatment you must submit a request in writing to Barry E. Yelk D.M.D., 1569 Medical Dr. Suite 102, Pottstown, PA 19464. If you request a copy we may charge you for copying, mailing, and other supplies used in the reproduction of the requested information. Please note – your request may take 7-10 business days to process.

We may deny your request in certain limited circumstances. If you are denied access to information you have the right to request that your denial be reviewed. Another licensed health care professional chose by the practice will review the request and denial. We will abide by the outcome of the review.

Right to Amend. If you feel that Dental/Medical information we have is incorrect or incomplete, you may ask to amend the information. You have the right to request an amendment for as long as your information is kept by the practice. You should contact the office at 610-326-2772 to make an appointment to discuss this process.

Right to an Accounting of Disclosure you have the right to request an accounting of disclosures. This is a list of disclosures of Dental/Medical information about you. You should contact the office at 610-326-2772 to set up a time to discuss these procedures.

Right to request a restriction. You have the right to request restrictions or limitations on the Dental/Medical information that we use or disclose for treatment payment or health care operations. You also have the right to request we limit the amount of information that we disclose about you to someone in your care, like a family member or a friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed in an emergency. You must make your request in writing to Barry E. Yelk D.M.D.

Right to a paper copy of this notice. You have the right to a paper copy of this notice any time. To obtain a copy of this notice ask at the front desk.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for Dental/Medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office. The notice will contain on the first page, in the top right-hand corner, the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice officer contact us at 610-326-2772. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of Dental/Medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission, you many revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose Medical/Dental information about you for the reason covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.