

NEW PATIENT INFORMATION FORM

NAME (Last, First, Middle) : _____ TITLE: _____

HOME ADDRESS: _____ City: _____

PREFERRED NAME: _____ SS NO: - - - DOB: ___ / ___ / ___

HOME PHONE: _____ MARITAL: S/M/D/W REF. DOCTOR: _____

WORK PHONE: _____ SEX: M / F REF. PATIENT: _____

MEDICAL ALERTS: _____

PRIMARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____

SS NO: - - - EMPLOYER: _____

DOB . ___ / ___ / ___ ADDRESS : _____

PLAN NAME: _____ GROUP NO: _____

INSURANCE CO: _____ IND YRLY DEDUCT: _____

ADDRESS: _____ FAM YRLY DEDUCT: _____

SECONDARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____

SS NO: - - - EMPLOYER: _____

DOB . ___ / ___ / ___ ADDRESS : _____

PLAN NAME: _____ GROUP NO: _____

INSURANCE CO: _____ IND YRLY DEDUCT: _____

ADDRESS: _____ FAM YRLY DEDUCT: _____

MEDICAL INSURANCE COVERAGE

SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____

PLAN NAME: _____ GROUP NO: _____

* RESPONSIBLE PARTY:
Name and Address: _____

* Signature: _____ DATE: _____

PATIENT MEDICAL HISTORY

For Office Use Only

ID:

Patient's Name:	Today's Date:	Date of Last Visit:	Date of Medical History:
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Address:	City, State, Zip:
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Home Phone:	Birth Date:	Social Security Number:	Marital Status:
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Guarantor 1:	Work Phone:
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Guarantor 2:	Work Phone:
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Physician Name:	Physician Phone:
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Pharmacy:	Pharmacy Phone:
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

For Office Use Only

Medical Alerts:

Sex:		If female, please answer the following:
<input style="width: 95%;" type="text"/>	Y N	<input type="checkbox"/> <input type="checkbox"/> Are you taking Birth Control Pills? <input type="checkbox"/> <input type="checkbox"/> Are you pregnant? If Yes, # of weeks <input style="width: 30px;" type="text"/> <input type="checkbox"/> <input type="checkbox"/> Are you nursing?

Please answer the following:
Y N
<input type="checkbox"/> <input type="checkbox"/> Do you smoke or use tobacco?
For Office Use Only
BP: <input style="width: 60px;" type="text"/> Heart Rate: <input style="width: 60px;" type="text"/>

Please mark Y(yes) or N(no) to all of the following:

Y N Conditions	Y N Conditions	Y N Conditions																						
<input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Stroke																						
<input type="checkbox"/> <input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> <input type="checkbox"/> Hay Fever	<input type="checkbox"/> <input type="checkbox"/> Thyroid Problems																						
<input type="checkbox"/> <input type="checkbox"/> Allergies	<input type="checkbox"/> <input type="checkbox"/> Heart Attack	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis																						
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Heart Surgery	<input type="checkbox"/> <input type="checkbox"/> Ulcers																						
<input type="checkbox"/> <input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease																						
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Hepatitis A	<input type="checkbox"/> <input type="checkbox"/> Yellow Jaundice																						
<input type="checkbox"/> <input type="checkbox"/> Artificial Bones	<input type="checkbox"/> <input type="checkbox"/> Hepatitis B																							
<input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure																							
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> HIV+ AIDS																							
<input type="checkbox"/> <input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> <input type="checkbox"/> Kidney Problems																							
<input type="checkbox"/> <input type="checkbox"/> Cancer- Chemotherapy	<input type="checkbox"/> <input type="checkbox"/> Liver Disease																							
<input type="checkbox"/> <input type="checkbox"/> Colitis	<input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure																							
<input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse																							
<input type="checkbox"/> <input type="checkbox"/> Cosmetic Surgery	<input type="checkbox"/> <input type="checkbox"/> Pace Maker																							
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Pneumocystitis																							
<input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems																							
<input type="checkbox"/> <input type="checkbox"/> Drug Abuse	<input type="checkbox"/> <input type="checkbox"/> Radiation Therapy																							
<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever																							
<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Seizures																							
<input type="checkbox"/> <input type="checkbox"/> Fainting Spells	<input type="checkbox"/> <input type="checkbox"/> Shingles																							
<input type="checkbox"/> <input type="checkbox"/> Fever Blisters	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease																							
<input type="checkbox"/> <input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> <input type="checkbox"/> Sinus Problems																							
		<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;">Y N</th> <th style="width: 10%;">Allergies</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/></td><td>Aspirin</td></tr> <tr><td><input type="checkbox"/></td><td>Codeine</td></tr> <tr><td><input type="checkbox"/></td><td>Dental Anesthetics</td></tr> <tr><td><input type="checkbox"/></td><td>Erythromycin</td></tr> <tr><td><input type="checkbox"/></td><td>Jewelry</td></tr> <tr><td><input type="checkbox"/></td><td>Latex</td></tr> <tr><td><input type="checkbox"/></td><td>Metals</td></tr> <tr><td><input type="checkbox"/></td><td>Penicillin</td></tr> <tr><td><input type="checkbox"/></td><td>Tetracycline</td></tr> <tr><td colspan="2">Other: _____</td></tr> </tbody> </table>	Y N	Allergies	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	Dental Anesthetics	<input type="checkbox"/>	Erythromycin	<input type="checkbox"/>	Jewelry	<input type="checkbox"/>	Latex	<input type="checkbox"/>	Metals	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	Tetracycline	Other: _____	
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Other: _____																								

Medications:

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Y N

Is there any disease, condition, or problem that you think this office should know about that is not covered above?
If yes, please describe below...

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Notes:

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Signature: _____

Date: _____

(If Under 18, Parent or Guardian Signature Required)

Bruce R. Dietman, DDS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

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. A copy of our Notice accompanies this Consent. 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:

Contact Person: Bruce R. Dietman, DDS _____

Telephone: 717-657-1001 _____ Fax: 717-657-9853 _____

E-mail: _____

Address: 1330 N. Mountain Road, Harrisburg, PA 17112 _____

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 Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent 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 to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.**

Bruce R. Dietman, DDS

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)
