Healthy Smiles Dental

Matthew T. Kingston, DMD

144 S. Centerville Road
Lancaster, PA 17603
Phone: 717-945-7440
Fax: 717-431-9731
www.healthysmilesdentalpa.com

Welcome to Healthy Smiles Dental.
To help save time when you arrive for your first visit with us we have created the attached New Patient Forms. (See list below)
Please print a copy of each, carefully fill each out and then bring them to your first appointment.
We will review your information and enter it into our computer system to establish you as a patient in our office.
If for some reason you are unable to print these forms, please call our office at:
717-945-7440
and we will mail, email or fax them to you.

HEALTH HISTORY INFORMATION (3 pages)
NOTICE OF PRIVACY POLICY
RECORDS REQUEST

If you should have any questions or need further assistance please give us a call at
717-945-7440

Healthy Smiles Dental

Matthew T. Kingston, DMD

Health History Information

Patient Information

Date_____
Patient Name_____ Preferred Name_____
Address _____
City_____ State_____ Zip_____
Home _____ Cell_____ Work_____
Please circle best phone number to reach you: HOME CELL WORK
Email_____
Date of Birth_____ Social Security Number_____
Emergency Contact_____
Phone_____ Relationship to Patient_____
How did you hear about our office?_____

Financial Information

Responsible Party Information, if other than patient

Name_____ Relationship to Patient_____
Social Security Number_____ Date of Birth_____
Address _____
City _____ State _____ Zip_____
Home Phone_____ Work Phone _____
Cell Phone_ _____ Email_____

Dental Insurance Information

Primary:
Name of Insured_____ Relationship to patient_____
Insured's Date of Birth_____Insured's ID #_____ Insured's SS#_____
Insured's Employer_____ Location_____
Insurance Company _____ Group #_____
Claims Address_____

Secondary:
Name of Insured_____ Relationship to patient_____
Insured's Date of Birth_____ Insured's ID #_____
Insured's Employer _____ Location_____
Insurance Company_____ Group #_____
Claims Address_____

I hereby authorize and direct payment of the dental benefits, otherwise payable to me, directly to the dentist or dental entity.
I understand that any remaining portion that is not paid by my insurance company will be my responsibility.

X_____ _____
Patient Signature Date

As a courtesy to our patients with dental insurance, we will file all dental claims

Medical History Information

General Medical Information:

Please rate your health. Excellent Very Good Good Fair Poor

Has there been a change in your general health in the past year? Yes No

Your Physician: _____City_____ Phone No: _____

Specialist:_____City_____Phone No:_____

Date of last physical examination: Month _____Year _____

Currently under treatment by a physician? Yes No
Please explain_____
Do you engage in regular exercise? Yes No
Type_____
Do you need to take antibiotics prior to receiving dental or surgical care? Yes No Don't know
Name of antibiotic:_____

Major hospitalizations, surgeries, and blood transfusion:

DATE (Month/Year) *REASON*

_____

_____

Allergic or unusual reaction to any of the following?

__Penicillin __Opiates/Codeine __Sulfites Other Drugs: (List) Other Substances (food, Metals, etc)
__Sulfa Drugs __Latex __Amoxicillin _____ _____
__ Asprin __Epinephrine __Clindamycin _____ _____
Type of Reaction_____
Have you ever felt your heart beating rapidly after a dental injections?_____

Women Only:

Are you PREGNANT? ____ weeks? Trying to become pregnant?__ Not sure if you are pregnant? __

Using birth control pills___ Going through menopause?__ Post-menopausal?___

Consumption of Beverages and other substances: PLEASE CIRCLE ANSWER

Number of caffeinated beverages you drink in a day:
0 1-2 3-5 5+
Number of alcoholic beverages you drink in a week:
0 1-2 3-5 5 6-10 10+
Number of Carbonated beverages a day:
0 1-2 3-5 5+
Currently using any street or recreational drugs?
__ No ___Yes (Type?)_____

Have you ever used tobacco? __No __Yes
If yes, what type:
Cigarette___ Pipe/Cigar___ Smokeless___
Do you currently use tobacco? __No ___Yes
If yes, average number of uses per day:_____
For how many years? _____

Please CIRCLE any conditions that apply and also DATE/YEAR of diagnosis:

Arthritis
Artificial Joint/Joint replacement
*****_Require premed_____
*****_Year_____
Asthma
*****_Do you carry an inhaler____
Autism/ Asperger's
Back and/or Neck Fusion
Blood Disease
Cancer
_Type:_____
year**:**_____
Chemotherapy _year_**:**_____
Chronic dry mouth
C.O.P.D (_bronchodilator/steroid_)
Diabetes I or II
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Fainting or Dizziness
Fibromyalgia
Glaucoma
Heart Disease _year:_____
Heart Attack _year_**:**_____
***** _Do you carry nitroglycerin___
Heart Murmur
Hepatitis A
Hepatitis B
Hepatitis C
High Blood Pressure
High Cholesterol
HIV/AIDS
Kidney Disease
Liver Disease
Mental Disorder
Multiple Sclerosis
Respiratory Problems
Rheumatism
Sexually Transmitted Disease
Sinus Problems
Stroke
Thyroid Disease
Tuberculosis (TB)
Other Conditions:
_____
_____

Please list ALL of the medications you take: ***(Including prescription, over-the-counter, vitamins or supplements)***

Name of Medication	For What Condition	Dosage/Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Dental related questions:

Are you having any tooth pain now?	Yes	No
Do you feel nervous about having dental treatment completed?	Yes	No
Are you aware of grinding or clenching your teeth?	Yes	No
Do you wear any dental appliances?	Yes	No
Is it ever difficult to open or close your mouth?	Yes	No
Do you suffer from frequent headaches or migraines?	Yes	No
Do your gums ever bleed when you brush or floss?	Yes	No
Do you suffer from chronic dry mouth?	Yes	No
Have you ever been told you snore?	Yes	No
Do you suffer from sleep apnea?	Yes	No
Do you use a C-Pap machine?	Yes	No
Have you ever suffered with a cold sore?	Yes	No

If yes, please list what triggers them for you_____

Is there anything you would change about your smile?

_____

X_____ _____

Patient Signature *Date*

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health or medications, I will inform Dr. Kingston at my next appointment without fail.

Consent for Services

I, (print name)_____, hereby give ***Dr. Matthew Kingston*** and staff, my consent to perform dental treatment considered necessary.

- I understand that as the treatment proceeds there may be need to change the treatment plan. If this occurs I expect to be informed before any change is instituted.
- I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions during or following any treatment, I agree to report them to the office as soon as possible. I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.
- **When treatment plans are presented, the expected insurance payment is an estimate. If for any reason the Insurance Company does not pay the amount estimated, I will be responsible for the difference.**
- A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts over 60 days, unless previously written financial arrangements are satisfied.
- If it becomes necessary for my account to be turned over to a collection attorney, I will be responsible to pay all costs of collections, including attorney fees.
- As a courtesy, we will file your claim for you. We may accept direct payment from most insurance companies. We will estimate your deductible and the portion not covered by your insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due our office may be adjusted accordingly. If insurance has not paid claim within 60 days, patient is responsible to pay for services rendered and then reimbursed when insurance payment is received.
- Payment for services is expected at the time service is provided. If treatment requires multiple appointments, payment may be divided over the number of appointments. If an extended payment plan is desired, please ask us about the CareCredit program.
- One discount/coupon per visit where applicable. Not applicable with Care Credit, Citi Health or VIP.
- **We reserve a specific block of time for each of our patients. An appointment with you is a bond of trust that we will be here to serve you. We expect you to be present for each of your appointments. It is extremely difficult to provide you with the kind of treatment that you expect from us with constant short notice changes to our schedule. AS A RESULT WE RESERVE THE RIGHT TO CHARGE A $50 FEE FOR ALL CANCELLATIONS MADE LESS THAN 24 HOURS IN ADVANCED.**

I have read the above conditions of treatment and payment and agree to their content.

X_____ _____

Signature of patient, parent or guardian *Date*

Abuse or Neglect
We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security
We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement
As permitted or required by State of Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Documentation of Health Information
You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Authorization to Use or Disclose Health Information
Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Restrictions
You have the right to request restrictions on certain uses and disclosure or your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications
You have the right to request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable request for confidential communications.

Inspect and Copy Your Health Information
You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change. Your request may be denied if health information record in question was not created by our office, is not part of our records or in the records containing your health information are determined to be accurate and complete.

Request a Paper Copy of This Notice
You have the right to obtain a copy of the Notice of Privacy Practices Directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice. You have the right to express complaints to us or the Secretary of Health and Human Services is you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Family, Friends and Caregivers
We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are able to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

My medical information may be obtained and exchanged verbally to:

1. _____

2._____

(Name and Relationship)

Patient Acknowledgement

I hereby acknowledge that I have reviewed a copy of Matthew T. Kingston, DMD Notice of Privacy Practices.

_____

Print Patient Name

_____ _____

Patient/Guardian Signature **Date**

Healthy Smiles Dental

Matthew T. Kingston, DMD

Records Request

I _____, DOB_____, hereby authorize you to release any and all dental records for services that were rendered by you or under your supervision.

Practice Name:_____
Street Address:_____
City, State, Zip:_____
Practice Phone Number:_____

Please release my x-rays/records to: _Healthy Smiles Dental_____

_____
Patient Signature Date

Family Member(s)

_____
Name Date of Birth

_____
Name Date of Birth

_____
Name Date of Birth

_____
Name Date of Birth

Please send to:

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Fax: (717) 431-9731

Email: office@healthysmilesdentalpa.com