Welcome to Charlestown Dental

12 General Warren Blvd, Suite 400, Malvern, PA 19355

PATIENT INFORMATION

Today's Date ________________________ Male ______ Female ______ Marital Status ____________________

Name ____ Date of Birth ______________________________

Address ____ Apt No. ____________________

City ____ State ________________________ Zip Code ______________

Home Phone # _____________________________ Work Phone # ____

Cell Phone/Pager _____________________________ Email Address _____________________________________
(if you want to be contacted this way)

Social Security # ____________________ How did you hear about us? __________________________________

Person to contact in case of emergency

RESPONSIBLE PARTY

Name ____ Relationship to Patient __________________________

Address ____ City, State, Zip Code _________________________
(if different from above)

Home Phone No. ____________________________________ Work Phone #. ________________________________

Social Security #. _________________________________

INSURANCE INFORMATION

Employee Name ____________________ Employer Name ______________________ Insurance Co. ____________________

Group No. ________________ Employee Date of Birth ______________________ Employee SSN: ____________________

GENERAL DENTAL TREATMENT CONSENT, HIPAA - PHI CONSENT

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) ______________________________'s dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. I agree to the use of anesthetic, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that: Protected health information may be disclosed or used for treatment, payment, or health care operations. The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice. The Practice reserves the right to change the Notice of Privacy Practices. The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions. The patient may revoke this Consent in writing at any time and all future disclosures will then cease. The Practice may condition receipt of treatment upon the execution of this Consent.

Patient or Responsible Party ____ Date ______________________________

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Medical/Dental History Form (All information is completely confidential)

PATIENT NAME____DATE______________________

DENTAL HISTORY

How often do you have dental examinations? ____

How often do you brush your teeth? ____________________ How often do you floss?______________

What other dental aids do you use? (Interplak, toothpick, etc.)____________________________

Do you have any dental problems now? Yes No.

If yes, please describe: ____

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years?....... Yes No
   If yes, for what? ____
   Physician's Name _________________________ Phone ____________________________
   Address ___________________________ City _____________ State ________ Zip __________
2. Have you taken any medication or drugs the past two years?....... Yes No
3. Are you taking any medication, drug or pills now? .... Yes No
   If yes, please list name and dosage ____
4. Have you ever taken prescription medications for weight loss (diet pills)?....... Yes No
   If yes, did you take any of the following: Yes No Fen-Phen (Fenfluramine-Phenopermine)
   Yes No Pondimen (Fenfluramine)
   Yes No Redux (Dexfenfluramine)
   If yes to any of the above, did you have a medical exam for heart issues? .... Yes No
5. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance?....... Yes No
   If yes, please list: ____
6. Have you been a patient in the hospital during that past five years? .... Yes No
7. Indicate which of the following you have ad, or have at present. Circle "yes" or "no" to each item.

Heart (surgery, disease,)	Yes	No	Ulcers	Yes	No	Hepatitis A, B	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	High Blood Pressure	Yes	No
Smoker	Yes	No	Contact lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

8. Do you use more than two pillows to sleep? .... Yes No
9. Have you lost or gained more than 10 pounds in the past year? .... Yes No
10. Do you have or have you had any disease, condition, or problem not listed? .... Yes No
    If yes, please list:
    ____
11. **Women** Are you: **Pregnant?** Yes, _____Months No **Nursing?** Yes No **Taking birth control pills?** Yes No
    I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

    Patient/Guardian Signature ________________________________ Date ____________________