# Welcome

Helping you feel great about your teeth.

S. John Salivonchik , D.M.D., P.C.
Family and Cosmetic Dentistry

*Please take a few minutes to answer the following questions so we can better assist you.*

## Patient Information

TODAY'S DATE _____ BIRTH DATE _____ SOCIAL SECURITY # _____

(PATIENT) LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

OCCUPATION _____ ○ MALE ○ FEMALE ○ SINGLE ○ MARRIED ○ WIDOWED

HOME PHONE _____ CELL PHONE _____

E-MAIL _____ WORK PHONE _____

EMPLOYER _____

**In case of emergency contact:**

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

NAME _____ RELATIONSHIP _____ Phone _____

## Primary Dental Insurance (or provide copy of ID card)

(INDIVIDUAL RESPONSIBLE FOR THIS ACCOUNT) LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

RELATIONSHIP TO GUEST _____ BIRTH DATE _____ SOCIAL SECURITY # _____

STREET ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP CODE _____

RESPONSIBLE PARTY EMPLOYED BY _____ WORK PHONE _____

INSURANCE COMPANY _____

INSURANCE COMPANY ADDRESS _____ INSURANCE COMPANY PHONE # _____

SUBSCRIBER ID # _____ GROUP # _____

## Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to 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 doctor 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 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 _____ Date _____

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

# CONSENT TO PERFORM DENTISTRY

S. John Salivonchik , D.M.D., P.C.
Family and Cosmetic Dentistry

1. I hereby authorize and direct Dr. S. John Salivonchik and/or dental auxiliaries of his/her choice to provide dental services
2. I understand that there are risks involved in this treatment and that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I agree to the use of local anesthesia if necessary.
4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed.
5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face, and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse.
6. I understand that in the process of any dental procedure soft tissue trauma may occur.
7. We use the best and most up to date materials which combine both strength and esthetics. When we restore a tooth or teeth it is done with the intention of the restorations lasting a long time; however, the mouth is a wear and tear environment. It is realistic to expect some of the work to require repair and replacement over the years at an additional expense. We provide a period of 2yrs in which we will replace a broken or chipped porcelain restorations. Any defects in fabrication or workmanship will occur well within that time period. Some factors which will hasten the deterioration of dental work are grinding and clenching, having missing teeth, smoking, diabetes, dry mouth, inadequate home care and high sugar diet. It is required that patients maintain at least a 6 month recare appointment and that they wear any prescribed appliances for grinding and clenching.
8. I will be advised that the success of the dental treatment to be provided will require that the patient and parents follow post-operative and post-care instructions of the dentist/s. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist/s and his/her auxiliaries be maintained.
9. I hereby state that I have read and understand this consent and that all questions about the Procedures will be answered in a satisfactory manner, and I understand that I have the right to be provided answers to questions which I may arise during and after the course of treatment.
10. Appointments canceled without 48hrs notice will result in a $100.00 charge per hour scheduled with the Doctor or a $50.00 charge for a hygiene visit.
11. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Date: _____ Time:_____ AM PM File No. _____

Patient's Name:_____

Name of Parent or Guardian:_____

Relationship to Patient: _____

Signature of Patient or Parent or Guardian: _____

Our office accepts Cash, Personal Check, Visa, Mastercard, Discover, American Express and Care Credit.

S. John Salivonchik , D.M.D., P.C.
Family and Cosmetic Dentistry

**Our financial policy is designed to create the most consistent environment for out patient's care.**

Any checks, for which we receive notification by the bank of insufficient funds, will be charged a $25.00 fee.

Please understand if there is no payment activity within 60 days, the account will be transferred to a collection agency and subject to the collection fees and policy as outlined below.

We utilize an outside collection agency to collect on any outstanding balances which do not maintain an active/current payment status with our practice.

In the event your account is turned over to the collection agency. We will not be able to set-up payment plans with account collection balances. All collection account balances must be paid to the collection agency.

You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such a collection efforts.

Should your account be turned over to a collection agency, payment in full of any past due balance is expected prior to being seen in our office in the future. In addition, pre-payment in full will be expected prior to the time of service for any future care.

I have read and fully understand the financial policy set forth by Dr. Salivonchik D.M.D., P.C. and I agree to the terms of this financial policy.

_____ _____

Signature of patient and or guardian (SEAL) Date

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

S. John Salivonchik , D.M.D., P.C.
Family and Cosmetic Dentistry

## SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient #: _____ Social Security #: _____

## 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.

Your may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: _____ Sonya Galgon

Telephone: _____ 1005 Chestnut Street

E-mail: _____ Coplay, Pa 18037

Address: _____ (610)502-1545

**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.**

NAME _____ BIRTH DATE _____ TODAYS DATE _____

## Check any symptom(s) or condition(s) below that you currently have or have had in the past.

- ○ HIGH BLOOD PRESSURE
- ○ HEART MURMUR
- ○ MITRAL VALVE PROLAPSE
- ○ ARTIFICIAL HEART VALVE
- ○ CARDIAC PACEMAKER
- ○ CARDIOVASCULAR DISEASE, HEART ATTACK, STROKE OR BYPASS
- ○ ANGINA, CHEST PAIN
- ○ CONGENITAL HEART DISEASE
- ○ IRREGULAR HEARTBEAT
- ○ LOW BLOOD PRESSURE
- ○ ARTHRITIS
- ○ ARTIFICIAL JOINTS (KNEE, HIP, ETC)
- ○ ASTHMA
- ○ HAY FEVER OR SINUS PROBLEMS
- ○ BLEEDING DISORDER (ANEMIA, HEMOPHILIA, ETC)
- ○ EMPHYSEMA
- ○ TUBERCULOSIS
- ○ BRONCHITIS, CHRONIC COUGH
- ○ DIABETES
- ○ KIDNEY DISEASE
- ○ LIVER DISEASE
- ○ JAUNDICE
- ○ HEPATITIS (TYPE ___)
- ○ EPILEPSY OR SEIZURES
- ○ DEMENTIA OR ALZHEIMER'S
- ○ FAINTING SPELLS
- ○ NEUROLOGICAL CONDITION (MULTIPLE SCLEROSIS, PARKINSON'S, ETC)
- ○ THYROID DISEASE
- ○ EYE DISEASE OR GLAUCOMA
- ○ HEARING LOSS
- ○ HIV/AIDS
- ○ SEXUALLY TRANSMITTED INFECTION
- ○ CONTAGIOUS DISEASES
- ○ HERPES OR COLD SORES
- ○ CANCER IF YES WHAT TYPE ___
- ○ PSYCHIATRIC PROBLEMS
- ○ DEPRESSION, ANXIETY
- ○ HISTORY OF ALCOHOL OR DRUG ABUSE
- ○ HEADACHES, MIGRAINES
- ○ TOBACCO USE
- ○ OTHER: ____

## Questions

PHYSICIAN'S NAME _____ DATE OF LAST VISIT _____

Have you been advised to take **antibiotic** premedication prior to **routine dental work**? ○ YES ○ NO

If yes, give reason and antibiotic used _____

Have you ever had surgery and/or radiation for a tumor, growth or other condition? Explain: _____

Have you ever had abnormal bleeding following extractions or surgery? ○ YES ○ NO

Are you currently or have you taken bisphosphonate medication, such as Actonel, Reclast, or Fosamax. ○ YES ○ NO

Women. Are you pregnant? ○ YES ○ NO Are you nursing? ○ YES ○ NO

## Allergies

- ○ PENICILLIN
- ○ CODEINE
- ○ OTHER (PLEASE LIST) _____
- ○ ASPIRIN
- ○ NSAIDs (ADVIL, ALEVE, ETC)
- ○ LATEX
- ○ DENTAL ANETHESIA

## Medications

List any medications you are taking: _____

_____

_____

_____

_____

_____

Name of your Pharmacy: _____ Phone#: _____

Signature of Patient / Legal Guardian: _____ Date: _____

## Dental History

1. Reason for visit _____

2. When was your last dental visit? _____

3. How often do you brush your teeth? _____

4. What texture brush do you use? ❍ Soft ❍ Medium ❍ Hard

| | YES | NO |
|---|---|---|
| 5. Do your gums bleed while brushing? | ❍ | ❍ |
| 6. Do your gums bleed while flossing? | ❍ | ❍ |
| 7. Do you feel pain to any teeth when brushing or flossing them? | ❍ | ❍ |
| 8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids? | ❍ | ❍ |
| 9. Have you noticed any loosening of your teeth? | ❍ | ❍ |
| 10. Does food tend to become caught between your teeth? | ❍ | ❍ |
| 11. Do you have any sores or lumps in or near your mouth? | ❍ | ❍ |
| 12. Have you ever experienced any of the following problems in your jaw? | | |
| a. Clicking? | ❍ | ❍ |
| b. Pain (Joint, ear, side of face)? | ❍ | ❍ |
| c. Difficulty in opening or closing? | ❍ | ❍ |
| d. Difficulty in chewing? | ❍ | ❍ |

| | YES | NO |
|---|---|---|
| 13. Have you had any head, neck, or jaw injuries? | ❍ | ❍ |
| 14. Do you have frequent headaches? | ❍ | ❍ |
| 15. Do you clench or grind your teeth while awake or asleep? | ❍ | ❍ |
| 16. Do you bite your lips or cheeks frequently? | ❍ | ❍ |
| 17. Have you ever had: | | |
| a. Orthodontic treatment (braces)? | ❍ | ❍ |
| b. Oral surgery? | ❍ | ❍ |
| c. Gum treatment? | ❍ | ❍ |
| d. A bite adjustment? | ❍ | ❍ |
| e. A bite plane or other appliance? | ❍ | ❍ |
| 18. Are you satisfied with the appearance of your teeth? | ❍ | ❍ |
| 19. Have you ever had an upsetting experience in the dental office? | ❍ | ❍ |
| 20. Is there anything about having dental treatment that bothers you? | ❍ | ❍ |

## Other Concerns

Do you have any other concerns you think we should know about?: _____

_____

_____

_____

_____

**NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.** I certify that I have read the above and that the information given on this form is accurate. I Understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

# HIPPA
# Notice of Privacy Practices

*Revised 2013*

*Effective as of April/14/2003*
*Revised March/26/2013*

S. John Salivonchik , D.M.D., P.C.
Family and Cosmetic Dentistry

*Dr. S. John Salivonchik, D.M.D.*
*1005 Chestnut Street*
*Coplay, Pa 18037*
*(610) 502-1545*

## THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

## PLEASE REVIEW IT CAREFULLY

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

### USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This included the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human services to investigate or determine our compliance with the requirements under Section 164.500

### USES AND DISCLOSURES THAT REQUIRE YOUR AUTHOIZATION

**Other Permitted and Required Uses and disclosures** will be made **only with your consent, authorization** or the opportunity to object unless required by law. Without you authorization we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information without your authorization. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

**You may revoke the authorization,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

## YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information (fees may apply) –** Persuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to your or to another person, or information that was obtained under a promise of confidentiality.

**You have the right to request a restriction of your protected health information –** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your heath plan with respect to healthcare for which you have paid in full out of pocket.

**You have the right to request to receive confidential communications –** You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You have the right to request an amendment to your protected health information –** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures –** You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures, pursuant to an authorization, for purposes of treatment, payment healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

**You have the right to receive notice of breach –** We will notify you if your unsecured protected health information has been breached.

**You have the right to obtain a paper copy of this notice** from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

## COMPLAINTS

You may complain to us or to the Secretary of Health and Human services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

Sonya Galgon Phone (610) 502-1545 email: greatsmiles@RCN.com
HIPAA COMPLIANCE OFFICER

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying “acknowledgement” form. Please note that by signing the Acknowledgement form you are only acknowledging that you have received or been given the opportunity to receive a copy of our notice of Privacy Practices.

# HIPPA
# Notice of Privacy Practices

*Revised 2013*

*Effective as of April/14/2003*

*Revised March/26/2013*

## ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Dr. S. John. Salivonchik's Notice of Privacy Practices. By signing below I am "only" giving acknowledgement that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Patient Name (Type or Print) Date

_____

Signature

Patient _____ MR#_____ DOB ____/___/____

As our patient, we may need to communicate with you when you are not in the practice. To assure your privacy, we would like you to indicate your preferred method for us to communicate medical information to you and/or to others involved in your care. Please note that an "appointment reminder" is not classified as medical information.

**PLEASE INDICATE YOUR COMMUNICATION PREFERENCES BELOW:**

❑ I give permission to **leave medical information** pertaining to me, my dependent or child, at the numbers listed below:

| Method | Yes | No | Area Code, Phone #, Extension |
|---|---|---|---|
| Home | | | |
| Answering Machine | | | |
| Work Phone | | | |
| Cell Phone | | | |
| Pager | | | |

**Without specific permission,** we will **not** release any medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner etc.):

❑ Do **not release medical information** to anyone other than myself.

❑ I give **permission to release medical information** pertaining to me to the individuals listed below.

| Name | Relationship (i.e. spouse, parent, son, daughter, etc.) | Area Code, Phone # - Extension |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

I assume responsibility to inform the practice of changes in my phone number(s) or my preferences or to revoke this specific medical information authorization at any time.

_____ _____

Signature Date

**CONFIDENTIAL**