York Smile Care

Patient Information

Circle One: Dr/Mr/Mrs/MS/Miss

*First:*_________________________ *Middle:*_________ *Last:*_______________________ *Jr/Sr:*________

*Street:*____ *City:*____________ *State*_____ *Zip:*__________

*Home Phone:*__________________________________ *Work Phone:*______________________________

*Cell Phone:*___________________________________ *Patient's Employer:*________________________

*Email Address:*________________________________ *May we contact you by Email(circle)* ***Yes No***

*Age:*____ *Sex(circle)* ***M F*** *Date Of Birth:*__________ *SS Number:*_____________________________

*Emergency Contact:*____________________________ *Phone:*_____________________________________

How did you hear about York Smile Care?

□ Postcard □ Clipper Magazine □ Billboard □ Radio □ TV □ Internet □Other_____________________

□ Friend/Family Member (Name:________________________________)

Insurance Information

Do you have Dental Insurance?(circle) ***Yes No*** *Do you have Secondary Dental Insurance?(circle)* ***Yes No***

Primary Dental Insurance:

*Insurance Company:*___________________________ *Policy/SS#:*________________ *Group#:*_________

*Subscriber Name:*_____________________________ *Relationship to Patient:*_______ *Birth Date:*_______

Subscriber Employer:___________________________ Work Phone:_______________ Ext:_____________

Secondary Dental Insurance:

*Insurance Company:*___________________________ *Policy/SS#:*_______________ *Group#:*__________

*Subscriber Name:*_____________________________ *Relationship to Patient:*_______ *Birth Date:*_______

Subscriber Employer:___________________________ Work Phone:_______________ Ext:_____________

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand payment is due in full when services are rendered. I understand this office may not be a provider of my insurance & insurance may pay less than the actual bill of services. I authorize this office to bill my insurance and send any information needed to process my dental claim by mail, fax and/or by e-mail.

Signature: ____________________________________ **Date:** ___________________________

Relationship (if signed by authorized agent of Patient): ______________________________

Patient Name: ______________________________________ **Date:**___________

DENTAL HISTORY

Reason for today's visit:__________________________

Former Dentist:_________________________ ________ City/State:_____________ Date of last Dental visit:_______

Date of last Dental X-ray:_________________

Please √ boxes apply to you:

□ Bad breath	□ Food collection between teeth	□ Periodontal treatment	□ Bleeding gums	□ Gums swollen or tender
□ Broken filling	□ Dry mouth	□ Grinding teeth	□ Clicking jaw	□ Jaw pain
□ Loose teeth	□ Sensitivity to cold	□ Sensitivity to heat	□ Sensitivity to sweet	□ Sensitivity when biting

MEDICAL HISTORY

Do you have, or have you had, any of the following?

□ AIDS/HIV Positive	□ Chest Pains	□ Frequent Headaches	□ Irregular Heartbeat	□ Scarlet Fever
□ Alzheimer's Disease	□ Cold Sores/Fever Blisters	□ Genital Herpes	□ Kidney Problems	□ Shingles
□ Anaphylaxis	□ Congenital Heart Disorder	□ Glaucoma	□ Leukemia	□ Sickle Cell Disease
□ Anemia	□ Convulsions	□ Hay Fever	□ Liver Disease	□ Sinus Trouble
□ Angina	□ Cortisone Medicine	□ Heart Attack/Failure	□ Low Blood Pressure	□ Spina Bifida
□ Arthritis/Gout	□ Diabetes	□ Heart Murmur	□ Lung Disease	□ Stomach/Intestinal Disease
□ Artificial Heart Valve	□ Drug Addiction	□ Heart Pace Maker	□ Mitral Valve Prolapse	□ Stroke
□ Artificial Joint	□ Easily Winded	□ Heart Trouble/Disease	□ Pain in Jaw Joints	□ Swelling of Limbs
□ Asthma	□ Emphysema	□ Hemophilia	□ Parathyroid Disease	□ Thyroid Disease
□ Blood Disease	□ Epilepsy or Seizures	□ Hepatitis A	□ Psychiatric Care	□ Tonsillitis
□ Blood Transfusion	□ Excessive Bleeding	□ Hepatitis B or C	□ Radiation Treatments	□ Tuberculosis
□ Breathing Problem	□ Excessive Thirst	□ Herpes	□ Recent Weight Loss	□ Tumors or Growths
□ Bruise Easily	□ Fainting Spells/Dizziness	□ High Blood Pressure	□ Renal Dialysis	□ Ulcers
□ Cancer	□ Frequent Cough	□ Hives or Rash	□ Rheumatic Fever	□ Venereal Disease
□ Chemotherapy	□ Frequent Diarrhea	□ Hypoglycemia	□ Rheumatism	□ Yellow Jaundice

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain: ______________________________

Medications

List any medications you are currently taking:

____

____

Allergies

□ Aspirin □ Barbiturates □ Codeine □ Erythromycin □Penicillin
□ Latex □ Nickel □ Sulfa □ Local Anesthetic
□ Other____________

If you answer "yes" to any questions below, please specify:

Are you under a physician's care now?	□ Yes □ No	______________________________
Have you ever been hospitalized or had a major operation?	□ Yes □ No	______________________________
Have you ever had a serious head or neck injury?	□ Yes □ No	______________________________
Do you have a tobacco addiction?	□ Yes □ No	
Do you use controlled substances?	□ Yes □ No	

WOMEN: Are you □ Pregnant? □ Nursing? □ Taking oral contraceptives?

Physician's Name:_____________________________________ Phone Number__________________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN____**DATE**_____________

York Smile Care

OFFICE FINANCIAL POLICY

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we work hard to provide a variety of payment options to help you receive the dental care that you need and deserve in order to enjoy a health, beautiful smile with respect to your budget. Dental Treatment is an excellent investment in an individual's medical and psychological well being. We are always available to answer your questions or assist you in any way that we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the financial arrangements regarding their dental treatment.

Financial Policies and Information

Payment for dental services provided is required at the time of service. For our patients with dental insurance, this means that your deductible/co pay is due at the time of service. For the convenience of all our patients, we accept cash, check, American Express, Discover, MasterCard & Visa.

For our patients who do not have dental insurance, we offer the following options (excludes Orthodontics):

1. **5% discount:**
   When you pay for the total treatment by **cash/check**, you will receive a 5% discount. If you are 65 years or older and pay for the total treatment by **cash/check,** you will receive a 7% discount.

2. **Major Service Payment Option:**
   We offer a payment option for major work such as crown, bridge & denture based upon the # of visits that is needed for the treatment:

   Crowns: 2 payment option.

   We ask that you pay **1/2 of** your total treatment cost at the first appointment and the **second 1/2** at the insert date appointment.

   Bridges & Dentures: 3-4 payment option.

   3 appointment procedures: we ask that you pay **1/3** of your total treatment cost at your first appointment, **1/3** at your second visit and the **final 1/3** at your insert date appointment.

   4 appointment procedures: we ask that you pay **1/4 of** your total treatment cost at your first appointment, **1/4 each at your second and third appointments** and the **final 1/4 at** your insert date appointment.

3. **Patient Financing**
   By arrangement with financing company, Care Credit , we offer our patients, upon approval, a 0% interest, same as cash payment plan with no down payment, no annual fee and no prepayment penalty. Applying is easy and financing is available for people with a wide range of credit history. We can either apply for you or you can apply by phone or online from the comfort of your home. Please ask us for details.

Cancelled Appointments:

Please keep in mind that your appointment time has been reserved especially for you and we strongly encourage all patients to keep their appointments. An appointment is a mutual agreement between us and your, our patient. We agree that we will be on time and ready for you when you arrive at our office and you agree that you will arrive on time for your appointment. Please be aware that we require at least **24 hours** notice if you must change your appointment. Please be aware that there is a cancellation fee of **$25.00/ half hour scheduled** for any NO SHOWS /CANCELLATIONS without a 24 HOUR NOTICE prior to your appointment.

York Smile Care

Biju Cyriac DDS, PC

36 Leader Heights Road

York, PA 17403

INFORMED CONSENT

1. In order to make a thorough diagnosis of ___________________________ (Patient's name) dental needs, I hereby authorize the doctor and the staff of York Smile Care to take X-Rays, Study Models, Photographs and any other diagnostic aids that are considered to be necessary by the doctor.
2. Once the diagnosis has been made, I authorize the doctor to perform all recommended treatment that is mutually agreed upon by me and to utilize any assistance that is needed to provide proper care.
3. I agree to the use of sedatives, anesthetics and any other medication that is necessary. I am completely aware that the use of anesthetics contains certain risks. I have been made aware that I can ask for explanation of any possible complications.
4. I have read and understand York Smile Care Financial Policy .
5. I agree that I am responsible for all services rendered on behalf of me and/or my dependents. I am also aware that payment is due at the time of service and that any returned checks/insufficient payments will be assessed a $25 recovery fee and that payment in full will be due immediately.
6. I agree that if the account becomes delinquent due to non-payment, the account will be turned over to an outside collection agency. If it is turned over to an outside collection agency, I agree to pay any and all fees, including legal fees, court costs and any other costs involved in the collection of my account.
7. I understand that if I cancel an appointment with less than 24 hours notice, there will be a cancelled appointment fee of $25.00 per half hour scheduled which will be due before any future appointments can be made. This also applies to not showing up for any appointments without cancellations prior to 24 hours before scheduled appointments.
8. I also understand that my testimonials, before and after shots and any other info maybe used for marketing endeavors by the practice.
9. I also acknowledge that I have received a copy of York Smile Care's Notice of Privacy Practices.

____ ____________________

PATIENT/PARENT OR GUARDIAN (IF UNDER 18) SIGNATURE DATE

____

PLEASE PRINT NAME

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices. However, acknowledgement could not be obtained for the following reason:

- ❑ Individual refused to sign
- ❑ Communications barrier prevented obtaining the acknowledgement
- ❑ Emergency situation prevented us from obtaining the acknowledgement
- ❑ Other(please specify)____

York Smile Care

36 Leader Heights Road

York, PA 17403

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOU HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect **12/10/07** and will remain in effect until we replace it.

We reserve the right to change our privacy and terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we make the changes. Before we make a significant change in our privacy practices, we will change this Notice and the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For Example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment services we provide to you.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence and qualifications of healthcare professionals, evaluating practitioner and provider performance, conduct training programs, accreditation, certification, licensing and credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help you with your healthcare or payment of your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose your health information to notify or assist in the notification of (including identifying or locating) a family member, your person representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use of disclosure of your health information, we will provide you with the opportunity to object to such uses and disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information bases on a determination using our professional judgment disclosing only health information that is relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable interferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use or disclose your health information when we are required to so do by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert serious threat to your health or safety or the health or safety of others.

National Security: We may disclose military authorities the health information of armed forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as email, voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the same format you request unless we cannot practicably do so. **(You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this notice.)**

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last 6 years but not before 03/01/2006. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement except in an emergency.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (**You must make your request in writing).** Your request must specify the alternative means or location and provide satisfactory explanation as to how payments will be handled under the alternative means or location that you request.

Amendment: You have the right to request that we amend your health information. (**Your request must be in writing and it must explain why the information should be amended).** We may deny your request under certain circumstances.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are also entitled to receive this notice in written form.

QUESTIONS & COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or to alternative locations, you may complain to us using the contact information listed at the end of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way of you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Elisabeth Cyriac

Telephone: 717.741.0893

Fax: 717.741.3946

Address: 36 Leader Heights Road

York, PA 17403