Walnutport Dental Center

Karen M. Lehman, DDS

961 Riverview Drive • P.O. Box 118
Walnutport, PA 18088
610.767.5388

Our dental team is happy to welcome you (and your family) to our dental practice. We are pleased that you have chosen us to help care for your oral health. We want you to know that our dental team is committed to providing you with the highest quality of dental treatment.

We are happy to cooperate with patients who are covered by dental insurance. We only ask that you carefully read your policy to be sure that you are fully aware of any restrictions that apply to the benefits provided. **Dental insurance is a contract between the patient and the insurance company** for reimbursing some costs of dental services. It is **not a contract between the dentist and the insurance company.**

The fees we charge for services rendered to those who are insured are our usual and customary fees charged to **all** patients for similar services. Your policy may base its allowances on a fixed fee schedule which may or may not coincide with our usual fees. You should be aware that different insurance companies vary greatly in the types of coverage they make available.

Our team will be responsible to:

- Complete Insurance claims and submit them to your carrier for you within 24 hours of treatment.
- Use current ADA codes for correct reporting of procedures.
- Accept direct payment from your carrier (if they permit) and keep track of balances.
- If necessary, re-file your insurance a second time within a 60 day period.

Our Patients responsibilities include:

- To pay fees not covered by your plan at the time of treatment.
- To provide the office with necessary information concerning your insurance coverage to allow correct filing of claims.
- To understand that your plan is a contract between yourself, your employer and your insurance carrier. **Understand that the dentist does not have the power to make your plan pay.**
- **To pay any account balance in full if not paid by your insurance after 2 billing attempts.**

Please be assured that this office will always be happy to assist you.

Karen M. Lehman, DDS

I have read the attached correspondence and agree that I will be fully responsible for the total payment of procedures performed in this office including any amounts that are not covered by dental insurance.

_____ _____

Signature of patient (or guardian) **Date**

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Patient History

1. Patient name _____ Date _____
2. Name and Specialty of all current physicians and their office locations:

3. Last complete physical was (date) _____
4. All medications plus vitamin supplements you are currently taking:

5. Are you taking any blood thinning medications? YES NO
6. Are you now or have you ever taken medication to strengthen bone for conditions such as osteoporosis, multiple myeloma, Paget's disease, or cancer? YES NO
7. Are you allergic too or have you reacted adversely to any medications, foods, latex, etc.? YES NO
   List if yes:

8. List all past hospitalizations and reasons for each:

9. Do you smoke or drink? YES NO Quantity: _____
10. Are you pregnant? YES NO What Trimester: _____
11. Are you nursing? YES NO
12. Do you take birth control pills? YES NO
13. Have you been diagnosed with any of the following? Check if YES:

- ☐ Heart disease, heart attack, angina
- ☐ Congenital heart defects (from birth)
- ☐ High/Low blood pressure
- ☐ Blood disorders
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Artificial joints (hip, knee, etc.)
- ☐ Pacemaker/ prosthetic valve
- ☐ Kidney problems
- ☐ Sinus troubles, allergies, etc.
- ☐ Glaucoma
- ☐ Stomach/intestinal issues
- ☐ Colitis
- ☐ Breathing problems (asthma, COPD, etc.)
- ☐ Type I/Type II diabetes
- ☐ Cancer or chemotherapy
- ☐ Arthritis
- ☐ Dialysis treatment
- ☐ Cerebrospinal shunt
- ☐ Hepatitis/ liver disease
- ☐ Seizures/epilepsy
- ☐ STDs (syphilis, gonorrhea, etc.)
- ☐ Psychiatric treatment/ therapy
- ☐ Drug or alcohol addiction
- ☐ Eating disorders
- ☐ Genetic abnormalities/ syndromes
- ☐ Acquired immune deficiency syndrome or HIV
- ☐ Cholesterol treatment

COMMENTS (on any diagnosis or condition not listed):

14. Have you ever been informed you need a pre-medication prior to dental treatment? YES NO
15. When was your last dental exam? _____ Dental x-rays? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner.
I have answered all of the above medical and dental questions truthfully and to the best of my knowledge.

Patient Signature _____ **Date** _____

Dentist Signature _____

Walnutport Dental Center HIPAA Consent Form

Patient Name: _____Birthdate_____

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Walnutport Dental Center may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Though Walnutport Dental Center has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgment that you have received the Notice. Signing below indicates that you have received the Notice of Privacy Practice. If you have any questions, please contact our HIPAA Compliance Officer: Dr. Karen Lehman.

I hereby acknowledge that I have received a copy of Walnutport Dental Center's Notice of Privacy Practices, and I also understand my consent can be rescinded by written request. Walnutport Dental Center can also change their Notice of Privacy Practices at which point I will be able to review the policy and consent or decline my acceptance.

Signature of Patient/Guardian_____ Date_____

I ask that information regarding appointments and general information be left at the following phone number. _____

Permission to Share Medical Information

My Medical Information may be obtained and exchanged verbally to:

Name/Relationship_____

Name/Relationship_____

Permission to Bill Your Insurance

All professional services rendered are charged to the patient. An insurance clearinghouse is used to process your insurance carrier's claims. I understand my signature authorizes necessary protected health information be released to the insurer and clearinghouse to process my insurance claims.

Signature of Patient/Guardian_____ Date_____

Walnutport Dental Center

PATIENT REGISTRATION

(Please Print)

Patient _____
Last Name *First Name* *Initial*

Birth Date _____ Sex: M F Social Security # _____

Responsible Party (if minor) _____

Relationship to Patient _____

Street Address _____

City _____ State _____ Zip _____

Employer _____

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Contact _____ Phone _____

DENTAL INSURANCE

Name of Insured _____ Birth Date _____

Relationship to Patient _____ Social Security Number _____

Primary Insurance Company _____

Address _____

Phone Number _____ Group Number _____

Name of Subscriber _____ Policy Number _____

Secondary Insurance Company _____

Address _____

Phone Number _____ Group Number _____

Name of Subscriber _____ Policy Number _____

CONSENT

1. 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 the patient's dental needs.
2. I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand the results following dental treatment can not be predetermined and can lead to complications. I understand that I can ask for a complete recital of any possible complications.
4. I understand that my dental insurance is a contract between me and the insurance carrier and that I am fully responsible for all dental fees. These fees are due at the time of service unless other arrangements have been made. I also assign all insurance benefits to the Doctor which will be credited to my account. I understand that a 1.5% late charge may be added to any overdue balance.
5. I understand a fee for a missed or cancelled appointment may be assigned a charge.
6. I give employees of Walnutport Dental Center permission to leave pertinent information on my home answering machine and cell phone.

Signature _____ Date _____
(responsible party)