Doc Bresler's Cavity Busters - New Patient History Form

Patient's Name ____ Nickname ____________________

Date of Birth____________________ Age ________________________ ❑ Female ❑ Male

Address ____ City,State,Zip Code ________________________________

Home Phone ________________________________

Mother's Name ____ Occupation ____________________

Email Address ________________________________ Cell Phone ________________________________

Father's Name ____ Occupation ____________________

Email Address ________________________________ Cell Phone ________________________________

Medical History

Has the child had any history of, difficulty with, or diagnosis of any of the following:

YES NO
- ❑ ❑ ADD/ADHD
- ❑ ❑ Anemia
- ❑ ❑ Arthritis
- ❑ ❑ Asthma/Pulmonary Disease
- ❑ ❑ Autism/PDD
- ❑ ❑ Behavioral Problems
- ❑ ❑ Bladder
- ❑ ❑ Bleeding disorders*
- ❑ ❑ Blood Transfusions
- ❑ ❑ Bones/Artificial Joints

YES NO
- ❑ ❑ Cancer*
- ❑ ❑ Cerebral Palsy
- ❑ ❑ Developmental Delay
- ❑ ❑ Diabetes
- ❑ ❑ Epilepsy
- ❑ ❑ Fainting
- ❑ ❑ Genetic Disease*
- ❑ ❑ Growth Problems
- ❑ ❑ Hearing Problems
- ❑ ❑ Heart Disease or Murmur*

YES NO
- ❑ ❑ Hepatitis
- ❑ ❑ HIV+/AIDS
- ❑ ❑ Kidney Disease
- ❑ ❑ Latex allergy
- ❑ ❑ Liver Disease
- ❑ ❑ Measles/Mumps
- ❑ ❑ Mononucleosis
- ❑ ❑ Pregnancy (teens)
- ❑ ❑ Previous Surgeries*
- ❑ ❑ Previous Hospitalizations*

YES NO
- ❑ ❑ Rheumatic fever
- ❑ ❑ Ringworm
- ❑ ❑ Seasonal Allergies
- ❑ ❑ Seizures
- ❑ ❑ Sex. Trans. Disease
- ❑ ❑ Sickle cell*
- ❑ ❑ Thyroid
- ❑ ❑ Tobacco/Drug Use
- ❑ ❑ Tuberculosis
- ❑ ❑ Warts
- ❑ ❑ Other* __________

* Additional Information: ____

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Immunizations up to date ❑ YES ❑ NO

Medications ❑ NONE ____

Allergies (Medications, foods, etc) ❑ NONE ____

Name of Physician ________________________________ Phone ________________ Last Visit ______________

Dental History

Previous Dentist:____ Date of Last Visit: ________________

Date of Last Dental X-Rays: ________________________ Date of Last Dental Cleaning: ____________________

Specific Dental Concerns: ____

Consent for treatment:

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. I authorize the staff at Doc Bresler's Cavity Busters to perform such treatments, services, medications, local anesthesia, analgesia, and accepted behavior management techniques that may be necessary to correct any oral deficiency, abnormality, infection and/or disease. If any conditions are discovered in the course of treatment which, in the opinion of the doctors authorized by this consent, require procedures in addition to or different than those described, I also authorize the performance of these procedures. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained from treatment, I consent to the taking and publication of any photographs in the course of this treatment for the purpose of advancing dental education. I certify that I have read the above Consent and questions were answered to my satisfaction.

Parent's/Guardian's Signature ____ Date ______________

Dentist's Signature ____ Date ______________

David A. Bresler D.D.S, PC

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 YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by the Health Insurance Portability and Accountability Act (HIPAA), the HIPAA Omnibus Rule, the Health Information Technology for Economic And Clinical Health Act (HITECH), and applicable federal and state law to maintain the privacy of your Protected Health Information (PHI). 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 this Notice while it is in effect. This Notice takes effect 9/23/13, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the 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 made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make 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 the office where you receive treatment.

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 and disclose your health information to obtain payment for services we provide to you.

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

Your Authorization: In addition to our use of your PHI 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 a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. Other uses and disclosures not described in this Notice will be made only with authorization from the individual to whom the PHI relates.

Out of Pocket Fees Paid in Full: You have the right to restrict certain disclosures of your PHI to a health plan where you have paid out of pocket in full for an item or service by us.

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 with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose your PHI to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly 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 inferences 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. We will not disclose your PHI for sale or for any other uses not described in this notice without written authorization. We may contact you to raise funds, which you have the right to opt out of receiving such communication.

Breach Notification Rule (BNR) inclusion in the HITECH Act: If a risk assessment demonstrates a probability of a breach of PHI, we are required to provide notification to affected individuals and to the Secretary of HHS following the discovery of such breach.

Breaches of all data sets, regardless of content will be handled as a breach. If the breach is over 500 individuals, we must notify the media. Business associates will notify us within 60 days if they discover a breach.

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

HIV Related Information: This information has been disclosed by you from records protected by Pennsylvania law. Pennsylvania law prohibits us from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

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 a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized 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 voicemail messages, postcards, emails, text messages, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information (hard copy or electronic), with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the 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 contacting the office where you receive treatment. We may charge you a reasonable cost-based fee for expenses such as staff time. You may also request access by sending us a letter to the address of the office where you receive treatment. If you request copies, we may charge you $0 for each page, $25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact the office where you receive treatment for a full explanation of our fee structure.

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 September 23, 2007. 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.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. 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 how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your PHI. (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 from our website or by email, you are entitled to receive this Notice in written form.

QUESTIONS AND 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 PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may 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 if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Telephone: 215-483-6633

Fax: 215-483-7909

Main Address: 6801 Ridge Avenue, Philadelphia, PA 19128

Doc Bresler's Cavity Busters

Exceptional Dentistry for Children and Teens

David A. Bresler D.D.S. Joshua A. Bresler D.M.D. Jason M. Bresler D.M.D.
& Associates

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgement****

I, ___________________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please print name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

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Doc Bresler's Cavity Busters

Office Policies

Zero Balance Office: We do **NOT** bill patients - only Insurance Companies. Payment is due at the time of treatment. We accept cash, check, major credit cards, and Care Credit. We also have no interest and low interest payment plans through Care Credit. Please ask for information.

Recall Visit: Fluoride treatments & indicated x-rays are performed every 6 months unless you tell us otherwise.

Work: Dental treatment may include sealants, white (composite) fillings, silver (amalgam) fillings, pulp treatment (root canal), crowns, bondings, and/or extractions. Please check with your insurance company prior to your visit to see what procedures are covered and whether you will have a co-pay or deductible the day the services are rendered. Our doctors develop a treatment plan to provide the BEST care for your child - not based on what is covered by your insurance company.

Referrals or Insurance Forms: Required referrals or insurance forms must be brought in the day of your child's appointment or the visit will be rescheduled.

Emergencies: True emergencies involve severe pain, swelling or bleeding. We will do our best to accommodate true emergencies.

Leaving the Office: Please do not leave the office during your child's visit. Treatment plans sometimes change during the procedures and the doctor may need to speak with you.

No Show Policy: We have a strict "no-show" policy in place. You must call us 24 hours in advance if you cannot make your appointment. Anyone who misses 3 appointments without calling 24 hours in advance will be dismissed from the practice.

Communication Policy: For your convenience, we will now confirm your appointments, initiate reminders and newsletters, and report office closures through email, text (cellular provider rates may apply), or by phone. You may opt-out of the text messaging service by sending STOP to the text message you received. By signing below, you are consenting to our communication policy.

Predeterminations: These are only estimates. Your insurance company will not provide us a 100% accurate fee until the work is completed and they receive your claim from us. We try to gather as much information as we can, but please remember that insurance is a contract between *you* and your Insurance Company.

By signing this form, you acknowledge that you have received this form and adhere to the office policies of Doc Bresler's Cavity Busters. You also understand that this form is responsible for all family members.

____________________________________ ____________________
Patient Name (please print clearly) Date of Birth

____________________________________ ____________________
Signature of Parent/Guardian Date

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Email address (please print clearly)

revised 5/9/17

Doc Bresler's Cavity Busters

Dental Insurance / Financial Responsibility

Patient's Name: ____

Patient's Date of Birth: ____

Patient's Social Security Number: ______________________________________

Child's Insurance: ____

ID#: ________________ Group # (if applicable): ______________________

Father's Name: ______________________

DOB: ___________________________

Address: __________________________

City, State, Zip: ____________________

Home Phone No.: ____________________

Social Security No.: __________________

Employer: _________________________

Business Phone No.: _________________

Dental Insurance: ____________________

ID#: ____________________________

Group # (if applicable): ________________

Mother's Name: ______________________

DOB: ___________________________

Address: __________________________

City, State, Zip: ____________________

Home Phone No.: ____________________

Social Security No.: __________________

Employer: _________________________

Business Phone No.: _________________

Dental Insurance: ____________________

ID#: ____________________________

Group # (if applicable): ________________

Names and address of person responsible for child other than above:

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This office is happy to cooperate with individuals 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 the cost of dental services. It is not a contract between the dentist and the insurance company.

I understand that I am financially responsible for all services rendered by the Dentist. I understand any co-payments, deductibles, and/or procedure cost not covered or denied by my insurance company, (including coverage termination prior to the date services are rendered) are my responsibility. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to David A. Bresler DDS, PC. I certify that the insurance(s) listed here represents all coverage(s) in place as of today.

This Dental office is authorized to fill out and/or assist me to complete any and all insurance forms pertaining to services rendered.

____ ____________________

Parent/Guardian Signature Date

Print Name__________________________ Relationship to Patient ______________