

# WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

## 1

### ABOUT YOU

Today's Date: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First M. Mr Mrs Ms Dr

I prefer to be called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Apt/Condo #

\_\_\_\_\_ City State Zip

Single  Married  Divorced  Widowed  Separated

Hm #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ DL #: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Where & when are best times to reach you? \_\_\_\_\_

Whom may we Thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

Previous / Present Dentist: \_\_\_\_\_  
(Please Circle)

Last Visit Date: \_\_\_\_\_

## 2

### SPOUSE INFORMATION

His / Her Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Contact #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ SS #: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ DL #: \_\_\_\_\_

Person Responsible for Account: \_\_\_\_\_

Contact #: (\_\_\_\_) \_\_\_\_\_

Billing Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_ DL #: \_\_\_\_\_

## 3

### INSURANCE

#### Primary Insurance

Dental Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

#### Secondary Insurance

Dental Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

#### Neighbor or Relative not living with you (for emergency).

His / Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ City State Zip

## 4

### MEDICAL HISTORY

Do you have a personal physician?  Yes  No

Physician's Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Are you currently under the care of a physician?  Yes  No

Please explain: \_\_\_\_\_

CONTINUED ON BACK

Your current physical health is:  Good  Fair  Poor

- Do you smoke or use tobacco in any other form?  Yes  No
- Have you had any metal rods, pins or implants?  Yes  No
- Are you taking any prescription / over-the-counter or herbal supplemental drugs?  Yes  No
- Please list each one: \_\_\_\_\_
- Have you ever taken Fosamax, or any other bisphosphonate?  Yes  No
- Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath?  Yes  No

**For Women:** Are you using a prescribed method of birth control?  Yes  No  
 Are you pregnant?  Yes  No Week #: \_\_\_\_\_  
 Are you nursing?  Yes  No

**Have you ever had any of the following diseases or medical problems**

- |  |  |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding                  | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes / Fever Blisters        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol / Drug Abuse               | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia                             | <input type="checkbox"/> Y <input type="checkbox"/> N HIV+ / AIDS                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis                          | <input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized for Any Reason    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems                |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma                             | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion                  | <input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure             |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Chemotherapy              | <input type="checkbox"/> Y <input type="checkbox"/> N Lupus                          |
| <input type="checkbox"/> Y <input type="checkbox"/> N Colitis                            | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse          |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect            | <input type="checkbox"/> Y <input type="checkbox"/> N Osteoporosis / Paget's Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes                           | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker                      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing               | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Treatment          |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema                          | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy                           | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells                    | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures                       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches                 | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles                       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma                           | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever                          | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems                 |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack                       | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke                         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur                       | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery                      | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB)              |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia                         | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers                         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis                          | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease               |

Please list any serious medical condition(s) that you have ever had: \_\_\_\_\_

**Are you allergic to any of the following?**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin            | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine            | <input type="checkbox"/> Y <input type="checkbox"/> N Latex        | <input type="checkbox"/> Y <input type="checkbox"/> N Other        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin   |  |

Please list any other drugs/materials that you are allergic to: \_\_\_\_\_

Why have you come to the dentist today? \_\_\_\_\_

- Do you require antibiotics before dental treatment?  Yes  No
- Are you currently in pain?  Yes  No
- Have you ever had a serious/difficult problem associated with any previous dental work?  Yes  No
- Do you have fears about going to the dentist?  Yes  No
- Have you ever had gum treatment?  Yes  No

**Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)?**  Yes  No

- Your current dental health is:  Good  Fair  Poor
- Do you like your smile?  Y  N Do your gums ever bleed?  Y  N
- How many times a week do you floss? \_\_\_\_\_ a day do you brush? \_\_\_\_\_
- Type of bristles?  Soft  Medium  Hard
- How long do you use a toothbrush before replacing it? \_\_\_\_\_
- Are your teeth sensitive to heat, cold, or anything else? \_\_\_\_\_
- Have you lost any teeth?  Yes  No If yes, why? \_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Payment is due in full at the time of treatment** unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

**OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the patient named herein. Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**Doctor's Comments:** \_\_\_\_\_

**MEDICAL HISTORY UPDATE**

- I have read my medical history dated \_\_\_\_\_ and confirmed that it states past and present medical conditions. \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_
- I have read my medical history dated \_\_\_\_\_ and confirmed that it states past and present medical conditions. \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_
- I have read my medical history dated \_\_\_\_\_ and confirmed that it states past and present medical conditions. \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

**Emrick Dental**  
**Dr. A. Chaudhry**  
2571 Baglyos Circle, Suite B-30, Bethlehem, PA 18020  
(610) 317-2454

## **NOTICE OF PRIVACY PRACTICES**

This notice takes effect September 2013 and will remain in effect until we replace it. It describes how health information about you maybe used and disclosed by our practice and how you can obtain access to this information. Please review it carefully. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. Our privacy practices are developed to meet requirements as specified by law. If the law changes we will amend our privacy practices to reflect the changes in the law. We must follow the privacy practices that are described in this Notice while it is in effect. 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 laws, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, inform you of changes in the Notice by getting a new signed copy from you, and we will provide copies of the new Notice upon request. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:** We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

**Treatment:** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you, or to a care provider that is overseeing other health needs you may have.

**Payment:** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information, or we could require a 3rd party to aid in collection of unpaid balances that are due.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

**Individuals involved in Your Care or Payment for Your Care:** We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

**Disaster Relief:** We may use or disclose your health information to assist in disaster relief efforts.

**Required by Law:** We will disclose your health information when we are required to do so by law.

**Public Health Activities:** We may disclose your health information for public health activities as required by law, including disclosures to: Prevent or control disease, injury or disability; Report child abuse or neglect; Report reactions to medications or problems with products or devices; Notify a person of a recall, repair, or replacement of

products or devices; Notify a person who may have been exposed to a disease or condition; or Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

**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 the protected health information of an inmate or patient.

**Secretary of HHS:** We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker's Compensation:** We may disclose your personal health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Law Enforcement:** We may disclose your personal health information for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities:** We may disclose your personal health information to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government programs, and compliance with civil rights laws.

**Judicial and Administrative Proceedings:** If you are involved in a lawsuit or a dispute, we may disclose your personal health information in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

**Research:** We may disclose your personal health information to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information. It should however be noted that we typically do not participate in research projects and this release is unlikely.

**Coroners, Medical Examiners, and Funeral Directors:** We may release your personal health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose personal health information to funeral directors consistent with applicable law to enable them to carry out their duties.

**Fundraising:** By law, we may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving fundraising communications. Our office policy is to NOT fundraise with patient information.

**Other Uses and Disclosures of Personal Health Information:** If a situation arises that is not covered in the prior sections, we will seek your permission for health information disclosure, unless dictated to do so by law. Your privacy is important to us and we work hard to secure all patient health information to protect individual privacy.

## **YOUR HEALTH CARE RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. 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. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you still have the right to receive a printed, or if possible, an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for any explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Disclosure Accounting:** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

**Right to Request a Restriction:** You have the right to request additional restrictions on our use or disclosure of your person health information by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request, except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have on file.

**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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we decided it and explain your rights.

**Right to Notification of a Breach:** You will receive notifications of breaches of your unsecured protected health information as required by law.

**Electronic Notice:** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

**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 if you disagree with a decision we made about access to your health information or in response to a request you made to amend or strict the use or disclosure of your health information 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 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.

Privacy Contact: Jennifer Ozimek, Office Manager

Practice Name: Emrick Dental

Address: 2571 Baglyos Circle, Suite B-30, Bethlehem, PA 18020

Practice Phone Number: (610) 317-2454

Practice Email Address: Jennifer@emrickental.com

**Emrick Dental**  
**Dr. A. Chaudhry**  
2571 Baglyos Circle, Suite B-30, Bethlehem, PA 18020  
(610) 317-2454

**ACKNOWLEDGEMENT OF PRIVACY PRACTICES**  
**2013 Privacy Practices Notice Amendment**

I have had the opportunity to read the Patient Privacy Notice for this practice. I understand that I may ask for a copy to take with me at any time, and that an appointed person is available to answer any questions that I may have now, or in the future, regarding the use on my Personal Health Information.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

EMRICK DENTAL  
2751 BAGLYOS CIRCLE, SUITE B-30, BETHLEHEM, PA 18020  
601/317-2454

PHOTO CONSENT FORM

- I GRANT PERMISSION to Dr. A. Chaudhry and/or a member or members of his dental team to take facial photographs as part of my dental record.
- I DO NOT GRANT PERMISSION to Dr. A. Chaudhry and/or a member or members of his dental team to take facial photographs as part of my dental record.

I understand that these photos may be used for treatment presentation, continuing education and case review with another dental professional or dental laboratory personnel.

I further understand that these photos may also be used for marketing purposes and that any photos showing my full face and/or my name require my authorization for use.

I have been informed that I may rescind such authorization at any time by providing a written request to Dr. Chaudhry and/or a member of his dental team.

By signing below I am indicating that I have read and understand the above with regard to how my photo/photos may be used and that I so authorize such use.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Parent/Guardian Signature

\_\_\_\_\_  
Date