SONRISA OLD CITY DENTAL ARTS
MEDICAL HISTORY ASSESMENT FORM

In order for us to provide you with effective and safe dental care, we need to understand some basic information about your past and present health. Please answer these as best as you can. Your responses will be reviewed by the dentist. Circle the following yes or no which describes your history for questions that implicate yes or no answers. Use a question mark when you don't understand a question or are not sure of your answer.

Today's Date: _____

Last Name: _____ First Name: _____ Middle Initial: ____

Birth Date: _____ Age: _____ Sex: _____

Marital Status: Single: _____ Married: _____ Partnership: _____ Divorced: _____

Social Security Number: _____

Insurance Carrier: _____ Employer Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Other: _____

Best time to reach you? _____

Email Address:_____

Whom may we thank for referring you? _____
Previous/Present Dentist: _____
Last visit date: _____
Emergency Contact Name and Number: _____
My current physical health is? Good Fair Poor
Are you taking any prescription or over the counter supplement drugs? Please list each: _____
_____
_____
Do you smoke or use tobacco in any other form? Yes No
Have you ever taken Phen-fen? (Also known as Redux, or Pandimin): Yes No
Have you taken Bisphosphonates or medicine for osteoporosis ? Yes No
(For Women): Are you taking birth control pills? Yes or No
Are you pregnant? Yes No (Week # _____)
Are you nursing? Yes No

Are you allergic to any of the following (please circle if any apply to you):

ASPRIN	**ERYTHROMYCIN**	**PENICILLIN**
CODEIN	**JEWERLY/METAL**	**TETRACYCLIN**
LATEX	**DENTAL ANESTHETICS**	**OTHER_____**

Please List any other drugs or materials that you are allergic to:

DO YOU HAVE OR HAVE YOU EVER HAD OR BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS? Please circle yes or no

Y N	Anemia / Radiation Treatment	Y N	Hemophilia / Abnormal Bleeding
Y N	Artificial bones / joints / valves	Y N	Hepatitis A B C
Y N	Arthritis	Y N	High / Low Blood Pressure
Y N	Asthma	Y N	HIV / Aids
Y N	Blood Transfusion	Y N	Hospitalized for any reason?
Y N	Bleeding Disorders	Y N	Kidney Problems
Y N	Bacterial Endocarditis	Y N	Mitral Valve Prolapse
Y N	Cancer / Chemotherapy	Y N	Psychiatric problems
Y N	Congenital Heart Defects	Y N	Rheumatic /Scarlet Fever
Y N	Diabetes	Y N	Severe / Frequent Headaches
Y N	Difficulty Breathing	Y N	Shingles
Y N	Drug / Alcohol Abuse	Y N	Sickle Cell Disease /Traits
Y N	Emphysema / Glaucoma	Y N	Sinus Problems
Y N	Epilepsy / Seizures / Fainting spell	Y N	Tuberculosis (TB)
Y N	Fever Blisters / Herpes	Y N	Ulcers / Colitis
Y N	Heart Attack / Stroke	Y N	Venereal Disease
Y N	Heart Murmur	Y N	Shunts or Ports
Y N	Heart Surgery / or Pacemaker	Y N	Racing Heart / or Palpitations
Y N	Hernia Repair	Y N	Swollen Feet or Ankles
Y N	Frequent Nose Bleeds	Y N	Do you take insulin
Y N	Thyroid Disease	Y N	Do you take thyroid meds.?
Y N	Steroid therapy including cortisone	Y N	Hormone Therapy

DENTAL HISTORY

Why have you come to the dentist today? _____

Are you REQUIRED antibiotics before treatment? Y N

Are you currently in pain? Y N

Have you ever had a serious / difficult problem associated with previous dental work? Y N

Your current dental health is: Good Fair Poor

Do you like your smile? _____

Do your gums bleed? _____

Have you ever had periodontal disease? Y N

How many times a week do you floss? ____ A day do you brush?___ (type: soft medium hard)

I understand that the information I have given today is correct to the best of my knowledge. I also understand this information will be held in 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

Patient Payment Responsibility Notice

We accept Visa and Mastercard

NOTICE

IF YOU DON'T HAVE INSURANCE OR WE DON'T PARTICIPATE IN YOUR PLAN PAYMENT IN FULL IS EXPECTED AT TIME OF SERVICE

For Participating Insurance Plans:

COPAYS: Due At Time Of Service.

ANNUAL DEDUCTIBLE: Due at first non-diagnostic procedure.

CO-INSURANCE: As a courtesy, we will file your health insurance. Once payment is received from your insurance, you will be billed for any co-insurance that is due. Payment in full is expected within 30 days, any balance that is carried over to the next billing cycle will incur a $25 monthly service fee each month until balance is paid in full.

If your account is not paid in full within 30 days, any and all balances remaining on the account will be subject to a $25 monthly service charge. If your account is not paid in full within 60 days, it could be referred to a collection agency and additional expenses will be incurred to include 40% collection fee and court costs.

I have read, understand and agree to the Patient Payment Responsibilities listed above. I have been given a copy of this document.

_____Date:_____

Signature

SONRISA OLD CITY DENTAL ARTS
CANCELLATION POLICY

Dear Patient,

Please be aware that we realize your time is valuable. Please also realize that our office time is equally valuable. We make every effort to accommodate you and your schedule when making appointments for you.

If you schedule an appointment it is an expected courtesy on your behalf to give our office 24 hours notice if you are unable to keep your scheduled appointment so that we can give the time allotted to another patient.

To enforce this policy, we require a credit card number to be held on file in the event that you do not give our office 24 hours notice or do not keep your appointment.

You will be charged $75.00 for appointment broken or late cancellation.

Thank you for your understanding and abiding by this policy.

The staff at Sonrisa Old City Dental Arts.

_____ _____

Patient Signature Date

Notice of Privacy Practices

Effective Date: April 14, 2003

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.

If you have any questions about this notice, please contact the Facility Privacy Official by dialing the main medical office number.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment and billing-related information. This notice applies to all of the records of your care generated by the medical office, whether made by medical office personnel, agents of the medical office, or your provider. Your health insurance, hospitals and other treatment providers may have different policies or notices regarding the use and disclosure of your health information.

Our Responsibilities:

We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this notice.

Uses and Disclosures:

How we may use and disclose Health Information about you.

The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use health information about you to provide you treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other medical office personnel who are involved in taking care of you at the medical office. For example: a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the medical office also may share health information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: Members of the medical staff and/or quality improve-ment team may use information in your health record to assess the care and out-comes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may also combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and students for educational purposes. And we may combine health information we have with that of other medical offices to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

We may also use and disclose health information:

- To business associates we have contracted with to perform the agreed upon service and billing for it;
- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health-related benefits or services;
- To contact you as part of fundraising efforts;
- To inform Funeral Directors consistent with applicable law;
- For population based activities relating to improving health or reducing healthcare costs; and
- For conducting training programs or reviewing competence of healthcare professionals.
- When disclosing information, primary appointment reminders and billing/collections efforts, we may leave messages on your answering machine or voice mail.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include billing services, transcriptionists, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you, your insurance company or a third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Individuals Involved in Your Care or Payment for Your Care: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Future Communications: We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our facility is participating.

As required by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

State Specific Requirements: Many states have requirements for reporting, including population-based activities relating to improving health or reducing healthcare costs. Some states have separate privacy laws that may apply additional legal requirements. f the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the **Right to**:

- **Inspect and Copy**: You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by the medical office will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Amend**: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the medical office. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.
- **Accounting of Disclosures**: You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or healthcare operations where an authorization was not required.
- **Request Restrictions**: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.
  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
- **Request Confidential Communications**: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you at work instead of your home. The facility will grant requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.
- **A Paper Copy of This Notice**: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

  If the facility has a website you may print or view a copy of the notice by clicking on the Notice of Privacy Practices link.

To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the medical office and include the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the medical office by contacting the main number and asking for the Facility Privacy Official or with the Secretary of the Department of Health and Human Services. To file a complaint with the medical office, contact the Privacy Official. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you and documented in the doctor's office or clinic.

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: _____

Printed Name

_____ _____

Signature Date

Relationship to Patient
(if other than patient): _____

Witness: _____

Printed Name – Practice Representative

_____ _____

Signature Date

Revised 09/03

COMPOSTIE RESIN FILLINGS

Although silver amalgam fillings are considered acceptable restorations, there is a more natural-looking alternative which most people choose.

Composite resin fillings have been tested for years and have been proven to be superior in the following ways:

- **Composite material is more similar to natural tooth structure. It looks and feels like healthy, attractive teeth should look.**
- **Composite resin materials are bonded to your teeth and can potentially strengthen your tooth preventing fractures of your teeth which can happen with very large silver amalgam fillings. Silver fillings do nothing to strengthen your tooth, they just fill the hole created by the cavity in the tooth, and can expand over time causing pressure on the remaining tooth structure.**
- **Composite fillings can preserve more of your natural tooth structure. Silver amalgam fillings often require removal of more healthy tooth structure for their placement and to help hold them into your tooth. With a composite filling, only the diseased part of the tooth needs to be removed and repaired.**
- **The cost of the composite materials and the techniques required to place them are higher than for silver amalgam fillings, but we feel the benefits far outweigh the added costs.**

Most insurance companies will not pay for the additional cost of placing a composite resin filling in your posterior (back teeth and will only pay for the amount covered for a similar silver amalgam filling. (Insurance companies generally pay for the least expensive way to restore teeth. They consider posterior composites to be "cosmetic".)

It is because of this that we must make you aware that there may be an additional charge for the placement of a natural-looking tooth colored filling in your posterior teeth over what your insurance would cover for a silver amalgam filling.

It is important to note that we do NOT advocate replacing your old silver amalgam filings unless there is a problem with them (deterioration, new cavities, etc.) or you wish to have them replaced for personal reasons.

I have read, understand, asked questions, and consent to the above policy.

_____ _____

Signature Date

_____

Witness

SONRISA OLD CITY DENTLA ARTS
OFFICE POLICY I CONSENT FOR TREATMENT

* By signing this consent form, you authorize the dentist to take x-rays and perform the necessary dental procedures to improve your oral health, relieve you of pain I discomfort, detect cavities, abscesses, abnormalities, and to help prevent future dental problems.

* Since we are committed to providing the best dental care possible for patients, our fees reflect what is Usual & Customary for our area. However many insurance companies will arbitrarily set their own UC rates regardless of our area or state and pay accordingly to their schedules not our fees. Please not that the insurance companies do not guarantee payments or benefit percentages. Therefore, co-pays and benefits are estimations, thus, additional co-payments may be required from you after insurance payments are received

*We request your payment or co-payment at the time these services are provided. Our fee for service policy helps alleviate outstanding accounts, finance charges and the high cost of billing, thus maintaining UC fees, thus, maintaining our fees, and providing the most advanced dental care. However, if financial obligations are not met, accounts will be subject to finance I late charges according to the laws and regulations of the state of Pennsylvania as of January 1, 1999.

*In addition, you, the patient or legal guardian (if the patient is a minor) are fully responsible for the account at Son nsa Old City Dental Arts regardless of dental insurance. Dental insurance is a contract between employees / insured party, their employer and insurance company Not Sonrisa Old City Dental Arts**

*1 am aware that it is my responsibility to ask any questions, or relate any concerns I may have regarding the treatment, fees or my insurance (if applicable) prior to any procedure in order to make an educated decision regarding what is best for my dental health including no treatment at all. I agree that I am financially responsible for my treatment fees regardless of what my dental insurance covers. I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted and that this consent form does not encompass the entire discussion I had with the doctor and the staff.

*1 understand that the dental treatment may result in discomfort, soreness, bleeding, or swelling which may require several days for recovery. Other risk include injury to adjacent teeth, sensitivity, post treatment infection requiring further treatment, temporomandibular joint difficulty, treatment failure, complications resulting from the use of dental instruments, and possible bruising (black and blue) of the face.

*Dental injections, medications, anesthetics and treatment may also cause unfavorable reactions, an altered sensation, taste, or feeling of the lips, chin, cheeks, and I or tongue which is usually temporary but may be permanent. I understand that there are also other less likely inherent and potential risks in any dental procedure and that antibiotics may inhibit the effectiveness of birth control pills.

I acknowledge that I have read and understood this document and all questions have been answered completely. I consent to have treatment at Sonrisa Old City Dental Arts, LLC.

_____ _____

Signature of patient/parent/guardian (if minor) Date

_____ _____

Signature of office witness Date

Philadelphia Department of Public Health (2009)
Information Sheet — Amalgam dental fillings containing mercury

The Philadelphia Department of Public Health has developed this information sheet pursuant to Section 1, Title 9, Chapter 9-3100 of the Philadelphia Code. Its purpose is to give you information about amalgam fillings that contain mercury and other dental filling options.

Your dentist's office should provide you with a copy of this sheet and answer any questions that you may have.

1. What is dental amalgam?

- Dental amalgam is the silver-colored material used to fill (restore) teeth that have cavities, It is one of several approved choices for filling cavities.

- Amalgam is made up of 50 percent mercury, a type of metal. Amalgam also contains other metals including silver, tin, copper, and zinc.

2. Is dental amalgam that contains mercury safe?

- There is ongoing research and discussion about the health effects of mercury in amalgam fillings.

- Small amounts of mercury are released as a vapor (gas) when amalgam fillings are placed or removed and through chewing. This mercury can be absorbed by the body and may build up over time.

- High levels of mercury can cause toxic effects on the brain, nervous system, and kidneys.

- Generally, people with amalgam fillings have higher levels of mercury in their blood and urine than people without amalgam fillings. The mercury levels in people with amalgam fillings are not high enough to be considered toxic.

- So far, well-done studies have shown that amalgam fillings do not impact behavior, information processing, and kidney function among children.

- It is more difficult to study the long-term effects of dental amalgam (effects that may appear later in life). Research in this area is still being performed.

- The Food and Drug Administration (FDA), which regulates the safety of medications and medical devices, has stated that "dental amalgams contain mercury, which may have neurotoxic effects on the nervous systems of developing children and fetuses." The FDA is currently reviewing data and will make a decision about how strongly to regulate the use of amalgam.

3. Are there alternatives to amalgam?

- Yes. Amalgam is one of several approved choices for filling cavities.
- The most common dental filling used today is resin composite, which does not contain mercury Resin is usually tooth-colored
- Other filling materials are a form of glass cement, porcelain, gold, and other metals

4 Aside from safety issues, what are the pros and cons of amalgam and alternatives?

- Amalgam fillings generally last longer than resin composite fillings, so they don't need to be replaced as often.
- Resin composite fillings are tooth-colored and, therefore, are preferred by some people for cosmetic reasons
- There may be a cost difference between resin composite and dental amalgam.
- To protect the environment, amalgam must be disposed of as a hazardous waste.

5. What should you do?

- Talk to your dentist, ask questions, and make an informed choice about dental fillings if you have a cavity.
- Prevent cavities through regular brushing, flossing, and dental exams
- For more information on amalgam fillings that contain mercury:

The U.S. food and Drug Administration Questions and Answers on Dental Amalgam:
www.fda.gov/cdrh/consumer/amalgams. html

Centers for Disease Control Dental Amalgam Use and Benefits Fact Sheet:
http: //www.cdc.aov/oralHealthlpublications/factsheets/amalgam.htm

or call toll-free:

The US. Food and Drug Administration at

1-800-638-2041 (option #2) between 8:00 a.m. and 4:30 p.m.

A copy of this information sheet has been provided to the patient (or patient's representative) and his/her questions, if any, have been answered.

Patient signature_____ Date_____

Dentist signature_____ Date_____