

Patient Name _____

Medical Alert _____



Lancaster Cleft Palate Clinic

MEDICAL QUESTIONNAIRE

Please complete both sides of this medical/dental history form. All information is completely confidential.

Physician's Name _____ Date of last physical exam _____

Address _____ Phone _____

Check any of the following that you HAVE HAD or HAVE at present

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Anemia | <input type="checkbox"/> Endocarditis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fainting | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Drug/Alcohol Addiction | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Other _____ | | | |

YES NO

- Have you been hospitalized during the past two years? If yes, why? _____
- Have you ever had a major operation? Please list _____
- _____
- Have you been asked by your medical doctor to take antibiotics before dental treatment? _____
- Have you ever taken Phen-Fen or appetite suppressants? _____
- Have you ever taken bisphosphonates, such as Fosamax, Actonel, Boniva, Reclast, or Zometa? _____
- Do you smoke or use tobacco products? If yes, how much and how frequently? _____

Women, are you... Pregnant/Trying to get pregnant Nursing Taking birth control pills

Are you allergic to or have you reacted adversely to any of the following

- Aspirin Penicillin Barbiturates Local Anesthesia Codeine Acrylic Latex Metals
- Other Allergies _____

Please list all medications you are currently taking

Medicine _____	Condition _____
Medicine _____	Condition _____
Medicine _____	Condition _____
Medicine _____	Condition _____
Medicine _____	Condition _____

-over-

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DENTAL QUESTIONNAIRE

When was your last dental visit? _____ When were your last dental xrays? _____

YES NO

- Are you having any pain or discomfort? Please explain _____
- Do your gums bleed while brushing and flossing? _____
- Are your teeth sensitive to hot or cold? _____
- Have you ever experienced any of the following problems with your jaw?
Circle any that apply: Noise/Popping Pain Difficulty Opening/Closing Difficulty in Chewing
- Do you have frequent headaches? _____
- Do you clench or grind your teeth? If so, do you wear a guard? _____
- Have you ever had any orthodontic treatment? If so, do you wear a retainer? _____
- Do you wear dentures or partials? If so, how old are they? _____
- Do you have concerns about bad breath odor? _____
- Are you pleased with the appearance of your teeth when you smile? _____
- Have you ever had any serious problems with dental treatment? _____
- _____

The information that I have given today is correct to the best of my knowledge. I 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.

Patient/Guardian Signature

Date

In the event of an emergency please contact:

Name _____ Relationship _____ Phone _____

Initial medical/dental health reviewed by

Doctor's Signature

Date

Periodic medical/dental health reviewed by

Signature

Date

Signature

Date

Signature

Date

Signature

Date

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Patient Intake Form



Lancaster Cleft Palate Clinic & Lime Street Dentistry

PATIENT NAME:	BIRTHDATE:
PARENT NAME:	BIRTHDATE:
ADDRESS:	
PHONE NUMBER:	SECONDARY NUMBER:
SCHOOL NAME: (if child)	

PRIMARY FAMILY DOCTOR NAME & ADDRESS: _____

PRIMARY FAMILY DOCTOR PHONE: _____

WHOM MAY WE THANK FOR REFERRING YOU ? _____

Insurance/Parent's Information

Father
 Stepfather
 Guardian
 Self
 Mother
 Stepmother
 Guardian

NAME OF INSURED	NAME OF INSURED
ADDRESS (IF DIFFERENT FROM PATIENT)	ADDRESS (IF DIFFERENT FROM PATIENT)
EMAIL	EMAIL
NAME OF EMPLOYER	NAME OF EMPLOYER
WORK PHONE NO.	WORK PHONE NO.
SOCIAL SECURITY NO.	SOCIAL SECURITY NO.
BIRTHDATE	BIRTHDATE

DENTAL INSURANCE CO.	DENTAL INSURANCE CO.
PHONE NO.	PHONE NO.
GROUP NO.	GROUP NO.
POLICY/ID NO.	POLICY/ID NO.
MEDICAL INSURANCE CO.	MEDICAL INSURANCE CO.
GROUP NO.	GROUP NO.
POLICY/ID NO.	POLICY/ID NO.



Signatures

CHILD'S NAME: _____

Parent/Guardian Legal Information & Consent

I understand that the information I have given is correct and that it will be held in the strictest of confidence. I understand that it is my responsibility to inform the dentist and/or dental team member of any changes in my child's medical status. I authorize the dentist or interdisciplinary team member to perform diagnostic procedures and treatment as may be necessary for proper dental care. I acknowledge that I will be given the opportunity to discuss any recommended treatment prior to my child's appointment. I authorize the release of any information concerning the patient's health care for advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.

PLEASE PRINT YOUR NAME	
SIGNATURE	DATE

Office & Financial Policies

CONSENT & AUTHORIZATION: I authorize dental treatment for my child and agree to pay all related professional fees. I have read and fully understand the office and financial policies of Lancaster Cleft Palate Clinic and Lime Street Dentistry in its entirety. Without reservations, I agree to abide by the policies outlined herein.

I certify that the patient is covered by _____ (INSURANCE COMPANY NAME) and I assign directly to Lancaster Cleft Palate Clinic and Lime Street Dentistry, all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the use of my signature on all insurance submissions, whether manual or electronic.

The patient does not have dental insurance coverage. Please check:

PLEASE PRINT YOUR NAME	
SIGNATURE	DATE

Receipt of Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1966 requires that healthcare providers provide patients a copy of the office's Notice of Privacy Practices and make a good faith effort to obtain acknowledgement of receipt of the same. I acknowledge that I have received a copy of the Notice of Privacy Practices.

PLEASE PRINT YOUR NAME	
SIGNATURE	DATE

Acknowledgement of Clinic Policy

In order to maintain a quiet and peaceful environment for all of our patients and employees, we kindly request the following:

No cell phone use for personal calls in the clinical or waiting areas.

No cell phone photography or recording is permitted in the clinic or waiting areas without written permission from management.

All children must be supervised at all times by a responsible adult.

Children are not permitted to climb furniture, dental equipment or otherwise interfere with clinical or business activity in the building. This includes loud or disruptive behavior.

Inappropriate language or other disrespectful behavior will not be permitted.

Smoking, alcohol use, intoxication, and drug use are not permitted in the clinic or the parking lot.

Any failure to follow these policies may result in the need to reschedule your appointment. Repeated instances of inappropriate behavior may result in permanent dismissal from the clinic.

Patient Signature: _____ Date: _____

Parent Signature for minors: _____ Date: _____



Lancaster Cleft Palate Clinic & Lime Street Dental

CANCELLATION/PAYMENT POLICY

We make every attempt to respect your time and when you make an appointment, that time is being held just for you. We understand that emergencies happen, but ask that you contact us as soon as possible if you cannot keep a scheduled appointment.

APPOINTMENTS:

- Please give us 24 hours notice when canceling or changing an appointment. This allows us to use that time to serve someone else.
- **First broken appointment:** may be rescheduled.
Second broken appointment: will result in a charge of \$45.00, which will be billed directly to you. You may not make another appointment until this charge is paid.
Third broken appointment: we will provide treatment for 30 days on an emergency basis only. At that time, you are welcome to find another dental office.
- If you are an established patient and you arrive 10 minutes late or more to your appointment you may be asked to reschedule unless the clinician's schedule can still accommodate you.

You are responsible for remembering and keeping appointments. We do offer courtesy appointment reminders, by phone to help you avoid missed appointments.

PAYMENTS:

- Payment is expected at time of service.
If we participate with your insurance plan, copays are due at the time of service. We will provide an estimate that is good for 90 days. Please ask if you are unsure whether we participate with your insurance plan.
- If we do not participate with your insurance plan or you do not have insurance, payment in full is expected at the time of service or, if multiple visits are necessary to complete the procedure, by the time treatment is complete.
- Our office manager can discuss payment plan options with you.
- There is a \$35.00 fee for returned checks.



Lancaster Cleft Palate Clinic

RELEASE OF RECORDS

Patient Name _____ Date of Birth _____
 Address _____
 City _____ State _____ Zip Code _____
 Social Security Number _____ Phone Number _____

I would like records **OBTAINED FROM** – or – **RELEASED TO:**

Name of Organization _____
 Address _____
 City _____ State _____ Zip Code _____
 Phone Number _____ Fax Number _____

Name of Organization _____
 Address _____
 City _____ State _____ Zip Code _____
 Phone Number _____ Fax Number _____

Name of Organization _____
 Address _____
 City _____ State _____ Zip Code _____
 Phone Number _____ Fax Number _____

I authorize the use/disclosure of health information about me as described below

Date(s) of Service _____

- Complete Dental Record**
- Dental X-Rays**
- Complete Medical Record**
- Abstract of Hospital Medical Record** (History & Physical, Discharge Summaries, Consultation Reports, Operative & Procedure Reports, EKGs, Laboratory, X-ray and Imaging reports)
- Individual Results (please specify)** _____
- Immunization Record**
- Behavioral Health Reports** Social History Referral/Treatment Summary Psychological Evaluation
- Educational and/or Therapy Records (please specify)** _____

For the purpose of

- Further Medical Care Personal Insurance Changing Physicians Legal Investigation/Action
- Other (Please specify) _____



Lancaster Cleft Palate Clinic

State and Federal Law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records No Yes, dates: _____

HIV Testing and Results No Yes, dates: _____

Mental Health or Psychotherapy Records No Yes, dates: _____

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

- > I understand that if the use/disclosure of these records is for my own use, I will receive five copied pages from my medical record free of charge. If my request exceeds five pages, I may be charged no more than \$40.00 for up to 100 pages.
- > I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.
- > I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under the terms of this authorization.
- > I understand that I may revoke this authorization in writing at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Clinical Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. **This authorization expires in 90 days, unless otherwise specified.**

Signature of Patient or Personal Representative

Date

Name of Patient (Please print)

Signature of Witness

Date

IF PATIENT IS UNABLE TO CONSENT OR IS A MINOR

Patient is: Minor Incompetent Disabled Deceased
 Legal Authority: Custodial Parent Legal Guardian Executor of Estate of Deceased
 Power of Attorney for Healthcare Authorized Legal Representative

IF PATIENT IS PHYSICALLY UNABLE TO PROVIDE A SIGNATURE FOR RECORD RELEASE:

We, the undersigned, do verify that the above Authorization has been read to the client and that he/she has indicated understanding the nature of the Authorization and freely gives his/her verbal consent for the release of the above information.

Responsible Person's Signature

Date

PLEASE MAIL OR FAX THIS FORM TO:

Lancaster Cleft Palate Clinic
Medical Services-Release of Information
223 North Lime Street
Lancaster, PA 17602

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223 North Lime Street | Lancaster, PA 17602 | 717-394-3793 | 717-396-7409 Fax
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