Lancaster Cleft Palate Clinic & Lime Street Dentistry

Medical/Dental Questionnaire

MEDICAL ALERT:__________________

PATIENT'S NAME: ______________________________________ NICKNAME:____________________

LANGUAUGE(S) SPOKEN AT HOME: ______________

Medical/Dental History

PATIENT DOCTOR/PHYSICIAN:		PHONE NO.
DATE OF LAST PHYSICAL EXAM		
IS PATIENT FULLY VACCINATED? Y or N		
LIST OF ALLERGIES		
CURRENT MEDICATIONS/DOSAGES		
DATE OF LAST VISIT TO A DENTIST:		NAME OF PREVIOUS DENTIST:
DATE OF LAST DENTAL X-RAYS:		
DATE OF LAST DENTAL CLEANING?		
DOES HOME WATER CONTAIN FLUORIDE? Y OR N OR UNSURE		

Does patient have Congenital Heart Disease or Heart Murmur? Y N If YES, are antibiotics required? Y N

Has patient had any hospitalizations or surgeries? Y N Have you ever been told to take antibiotics before dental procedures? Y N

List all:____

Has patient ever had any history of the following? Please circle all that apply.

ADD/ADHD	Congenital Heart Defect	Kidney/Liver Disease	
AIDS/HIV	Convulsions/Seizures	Learning Disability	Premature birth/ Complications at birth
Anemia	Diabetes	Measles	Speech or Developmental Delay
Asthma	Drug/Alcohol Abuse	Mononucleosis	Cleft Lip/Palate
Artificial Heart Valves	Epilepsy	Mumps	Bleeding Disorder
Autism	Psychological Problems	Rheumatic Fever	Difficulty with Anesthesia
Bladder Problems	Hearing Impairment	Sinus Problems	Cancer/Tumors
Fainting	Heart Murmur	Thyroid Problems	Radiation of head/neck
Cerebral Palsy	Hepatitis	Tuberculosis	Vision/Eye Problems
Chicken Pox	Hemophilia		

OTHER:____

Does parent help patient (if child) with oral care at home? Y or N

Does patient brush daily? Y or N

Does patient floss daily? Y or

Is patient in pain or discomfort? Y or N

Does patient take fluoride in any form? Y or N

Any injuries to mouth, teeth, head? Y or N

Does patient clench or grind teeth? Y or N

Is patient in orthodontics? Y or N If yes, where? __________________

If child, does patient receive services through Early Intervention or the Intermediate Unit (IU)? Y or N

Any mouth habits? Check all that apply:

☐ Pacifier use ☐ Nail biting

☐ Baby bottle use ☐ Sippy cup use

☐ Nursing ☐ Mouth breathing

If child, does patient receive special services at school? Y or N

If yes for either, please specify:____

Any previous experiences, special needs or fears we should be aware of?

____
____
____
____

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 medical status. I authorize the dental staff to perform any necessary 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:________________________ Number:____________________

Initial medical/dental health reviewed by:

____ Date: ____________________________

Doctor's signature

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.

Lancaster Cleft Palate Clinic & Lime Street Pediatric Dentistry
Parental/Legal Guardian Consent for Dental Treatment

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR WHEN LEGAL GUARDIAN and/or PARENT(S) IS UNABLE TO BRING PATIENT

Please print:

I,____, parent or guardian of

____, a minor, do hereby authorize the following name(s); (example: name of friend, grandparent, aunt, uncle, neighbor, etc.)

a. ____

b. ____

c. ____

to consent for all medical & dental treatment, ie: x-ray, examination, anesthesia, medical/dental evaluation and/or treatment, surgery evaluation and/or treatment, diagnosis or care.

It is understood that this authorization is given to provide authority and power on the part of my aforesaid agent(s) to give specific consent to any and all such evaluation, diagnosis, office treatment, anesthetic administration or surgical treatment(s) which a physician/dentist, in the exercise of his/her best judgment, may deem advisable.

This authorization also grants to my agent(s) the power to sign for release of information to any third party payers who may be responsible for part or all of the cost of the services provided.

This authorization shall be effective until one (1) year from date signed

_____/_____/_____ ____

Date Signature of parent, guardian or other legal representative

Lancaster Cleft Palate Clinic & Lime Street Dentistry

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 e☐ort 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 PHYSICIALLY 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 LimeStreet
Lancaster, PA 17602