**O'Leary Dental Office** 35 West Main Street, North East, PA 16428 814-725-4705

Joseph M. O'Leary, DDS G. Peter Moylan, III, DMD

Please fill out these forms completely. The better we communicate, the better we can care for you!

## ACCOUNT INFORMATION

Name: _____ Nickname: _____ Date of Birth: ___/___/____
First Middle Last

Address: _____City: _____ State:_____ Zip: _____

Married / Single

Home Phone #: (_____)_____-_____ Work Phone(_____)_____-_____ Cell (_____)_____-_____ Widowed / Divorced

Social Security # _____-____-_____ Whom May We Thank for Referring You?_____

Employer: _____
Name Address Phone

## SPOUSE INFORMATION

Name: _____ Nickname: _____ Date of Birth: ___/___/____
First Middle Last

Address: _____City: _____ State:_____ Zip: _____

Married / Single

Home Phone #: (_____)_____-_____ Work Phone:(_____)_____-_____ Cell (_____)_____-_____ Widowed / Divorced

Social Security # _____-____-_____ Whom May We Thank for Referring You?_____

Employer: _____
Name Address Phone

## ****Terms and Conditions****

**At our office** you will find that we have a special "commitment to excellence" imperative. Yet you will find that because of our continuing efforts at cost containment, our fees are extremely reasonable. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

**We feel** that it is important for you to have a clear understanding of our financial policies. In this way we can prevent any further misunderstandings. Please note, a service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days. All emergency dental services, or dental work performed without previous financial arrangements must be paid at the time of service.

**While insurance may** help you pay for those services, *you are* ***ultimately responsible for payment***. Payment in full is required at time of services unless other arrangements have been made in advance.

**I hereby state that all information supplied above is correct. I have read and understand the above terms and conditions, and hereby fully agree with their content.**

**Signature of Account Guarantor**: _____ Date: _____

| Primary Insurance | | Secondary Insurance | |
|---|---|---|---|
| Subscriber Name | | Subscriber Name | |
| Subscriber SSN | | Subscriber SSN | |
| Date of Birth | | Date of Birth | |
| Relation to Subscriber | | Relation to Subscriber | |
| Employer Name | | Employer Name | |
| Employer Phone | | Employer Phone | |
| Insurance Company | | Insurance Company | |
| Insurance Group # | | Insurance Group # | |
| Insurance Phone # | | Insurance Phone # | |

***Please present insurance card to receptionist for photocopying***

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me**. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts.**

By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payer. I attest to the accuracy of the information on this page.

Signature of Account Guarantor: _____ Date: _____

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## PATIENT INFORMATION

Name: _____ Nickname: _____
First Middle Last

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: (_____)_____-_____ Work Phone(_____)_____-_____ Cell (_____)_____-_____

Marital Status (please circle)

Date of Birth: ___/___/_____ Sex: ____ Social Security # _____-____-_____ Single/ Mar / Wid / Div / Sep

Employer: _____
Name Address Phone

Physician's Name: _____ Phone: _____

Pharmacy: _____ Phone: _____

Whom May We Thank for Referring You?

_____

## MEDICAL HISTORY

What is the reason for your visit today? _____

Are you having any dental problems now? Yes No If so, please describe: _____

_____

Date of Last Dental Visit & Where: _____ Last dental cleaning: _____ Last X-rays:_____

**Do you require antibiotics prior to dental treatment?** Yes No If yes, previous prescription: _____

Have you been under the care of a medical doctor during the past two years? Yes No If yes, for what? _____

_____

Physician's Name: _____ Phone: _____

Have you been a patient in the hospital during the past 5 years? Yes No If yes, list dates and reasons: _____

_____

Are you aware of having an allergic (or adverse reaction) to any medication or substance? Yes No If yes, please list: _____

_____

Are you allergic to:

| Y | N | | Y | N | | Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Metals | ☐ | ☐ | Aspirin | ☐ | ☐ | Latex or Rubber Materials | ☐ | ☐ | Tetracycline | ☐ | ☐ | Dental Anesthetics |
| ☐ | ☐ | Codeine | ☐ | ☐ | Erythromycin | ☐ | ☐ | Jewelry | ☐ | ☐ | Penicillin | ☐ | ☐ | Other _____ |

Have you ever experienced pain in your jaw joint (TMJ / TMD) Yes No If so, please explain: _____

_____

Have you ever taken any biophosphonates ( such as Bonica, Areida, Fosamax, Actonol or Zometa)? Yes No If yes, please list: _____

**Please List Any Medications you are taking:**

| | | | | |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**Please indicate which of the following you have had, or have at present. Please give details if needed.**

| Y | N | Conditions |
|---|---|---|
| ☐ | ☐ | Abnormal Bleeding |
| ☐ | ☐ | Alcohol Abuse |
| ☐ | ☐ | Allergies - Hives |
| ☐ | ☐ | Anemia |
| ☐ | ☐ | Angina Pectoris |
| ☐ | ☐ | Arthritis |
| ☐ | ☐ | Artificial Bones |
| ☐ | ☐ | Artificial Heart Valve |

When: _____

_____

| Y | N | Conditions |
|---|---|---|
| ☐ | ☐ | Asthma |
| ☐ | ☐ | Blood Transfusion |
| ☐ | ☐ | Cancer / Chemotherapy |
| ☐ | ☐ | Chest Pain |
| ☐ | ☐ | Colitis |
| ☐ | ☐ | Congenital Heart Defect |
| ☐ | ☐ | Cosmetic Surgery |
| ☐ | ☐ | Chronic Cough |
| ☐ | ☐ | Depression or Anxiety |
| ☐ | ☐ | Diabetes |
| ☐ | ☐ | Difficulty Breathing |
| ☐ | ☐ | Drug Abuse |
| ☐ | ☐ | Emphysema |
| ☐ | ☐ | Epilepsy |

| Y | N | Conditions |
|---|---|---|
| ☐ | ☐ | Fainting Spells |
| ☐ | ☐ | Frequent Headaches |
| ☐ | ☐ | Glaucoma |
| ☐ | ☐ | HIV + or AIDS |
| ☐ | ☐ | Hay Fever |
| ☐ | ☐ | Heart Attack When: _____ |

_____

_____

| ☐ | ☐ | Heart Murmur |
|---|---|---|
| ☐ | ☐ | Heart Surgery When & |

Type: _____

_____

| ☐ | ☐ | Hemophilia |
|---|---|---|
| ☐ | ☐ | Hepatitis A, B or C (Circle) |
| ☐ | ☐ | Herpes |
| ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | Hospitalized w/in Past 2 |

Years? List Dates and Details: ____

_____

_____

_____

| ☐ | ☐ | Kidney Problems |
|---|---|---|
| ☐ | ☐ | Mitral Valve Prolapse |

| Y | N | Conditions |
|---|---|---|
| ☐ | ☐ | Nerves or Anxiety |
| ☐ | ☐ | Liver Disease |
| ☐ | ☐ | Low Blood Pressure |
| ☐ | ☐ | Pace Maker |
| ☐ | ☐ | Pneumocystitis |
| ☐ | ☐ | Prosthetic Valves or Joints |

What and Dates:_____

_____

_____

_____

| ☐ | ☐ | Psychiatric Problems |
|---|---|---|
| ☐ | ☐ | Radiation Therapy |
| ☐ | ☐ | Rheumatic Fever |
| ☐ | ☐ | Seizures |
| ☐ | ☐ | Shingles |
| ☐ | ☐ | Sickle Cell Disease |
| ☐ | ☐ | Sinus Problems |
| ☐ | ☐ | Stroke When:_____ |

_____

| ☐ | ☐ | Swollen Ankles |
|---|---|---|
| ☐ | ☐ | Thyroid Problems |
| ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Tumors |
| ☐ | ☐ | Ulcers |

| Y | N | Conditions |
|---|---|---|
| ☐ | ☐ | Venereal Disease |
| ☐ | ☐ | Do you smoke? |
| ☐ | ☐ | Do you use tobacco / chew? |

**Additional Conditions Not Listed Previously:** _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**Females, Please answer the following:**

☐ ☐ Are you pregnant? If yes, # of Weeks _____

☐ ☐ Are you nursing?

☐ ☐ Are you taking birth control medications?

## EMERGENCY CONTACT INFORMATION

In Case of Emergency Please Contact: _____

Relationship: _____ Home Phone: _____ Work or Cell # _____

## ACKNOWLEGEMENT AND AUTHORIZATION

***I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication. I authorize the dental staff to perform any necessary dental services that I may require during diagnosis and treatment with my informed consent.***

Patient/Guardian Signature: _____Relationship:_____ Date: _____

## HIPAA CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**SECTION A: NAME OF PATIENT GIVING CONSENT:** _____

**SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY. : Purpose of Consent**: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. **Notice of Privacy Practices**: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read a copy of our consent carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: O'LEARY DENTAL OFFICE, 35 W. Main St., North East, PA 16428 814-725-4705. **Right to Revoke**: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Records May be released to: _____

Records MAY NOT be released to: _____

**PRINT NAME:** I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations. *YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.*

Signature: _____ _____ Date: _____

**If this Consent is signed by a personal representative on behalf of the patient, complete the following:**

Personal Representative's Name: _____Relationship to Patient: _____