DESIGNER OF SMILES
STEVEN C BUNTING DDS
The Center for Aesthetic & Restorative Dentistry
3443 HUNTINGDON PIKE ■ HUNTINGDON VALLEY, PA 19006
PHONE: 215.947.4111 ■ FAX: 215.947.9820

Patient Medical History

Patient's Name | Today's Date

Address | Birth Date

City | State (Select) | Zip | Social Security

Email | Marital Status

Mobile Phone | Work Phone | Home Phone

Physician Name

Physician Phone

Pharmacy | Pharmacy Phone

☐ Yes ☐ No Do you smoke or use tobacco

Sex (Select)

If female please answer the following:

Yes	No		Yes	No	
☐	☐	are you taking Birth Control Pills	☐	☐	are you pregnant / # of weeks ☐☐
			☐	☐	are you nursing?

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Disease	☐	☐	Epilepsy/Seizures	☐	☐	Radiation Therapy
☐	☐	Heart Attack	☐	☐	Chronic Cough	☐	☐	Cancer – Chemotherapy
☐	☐	Chest Pain / Angina	☐	☐	Tuberculosis	☐	☐	Kidney Problems
☐	☐	Heart Murmur	☐	☐	Asthma	☐	☐	Liver Disease
☐	☐	High Blood Pressure	☐	☐	Hay Fever	☐	☐	Neurological Disorders
☐	☐	Low Blood Pressure	☐	☐	Allergies	☐	☐	Fever Blisters/Canker Sores
☐	☐	Mitral Valve Prolapse	☐	☐	Sinus Problems	☐	☐	Gerd/Reflux
☐	☐	Stroke	☐	☐	Fainting Spells			
☐	☐	CHF (Congestive Heart Failure)	☐	☐	Arthritis/Rheumatism			
☐	☐	Heart Pacemaker	☐	☐	Artificial Joints			
☐	☐	Defibrillator	☐	☐	Osteoporosis			
☐	☐	Swollen Ankles	☐	☐	Hepatitis A			
☐	☐	Diabetes	☐	☐	Hepatitis B			
☐	☐	Diet/Special/Restricted	☐	☐	Hepatitis C			
☐	☐	Ulcers	☐	☐	Hemophilia			
☐	☐	Thyroid Problems	☐	☐	Blood Transfusion			
☐	☐	Glaucoma	☐	☐	Bruise Easily			
☐	☐	Pulmonary/Respiratory	☐	☐	HIV +			
☐	☐	COPD	☐	☐	Aids			
☐	☐	Sarcoidosis	☐	☐	HPV			
☐	☐	Emphysema	☐	☐	Venereal Disease			

Allergies

Yes	No	
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other_____

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Patient Medical History (con't.)

Medications

Additional Medications

Account/Insurance Information

Employer

Dental Insurance Company

Address

Group #

ID #

Name of Subscriber, if not patient

Birthdate

Social Security #

Please complete if patient has secondary dental insurance.

Employer

Dental Insurance Company

Address

Group #

ID #

Name of Subscriber, if not patient

Birthdate

Social Security #

Emergency Contact/Referral Information

Name of person to contact in the event of an emergency

Relationship

Primary phone #

Patient Name (please print)

Patient, Parent or Guardian Signature

Date

(If Under 18, Parent or Guardian Signature Required)

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Patient Dental History

Patient's Name

Today's Date

Reason for today's dental appointment

Are you having a problem which requires immediate treatment

☐☐/☐☐/☐☐☐☐ Date of last dental cleaning

☐☐/☐☐/☐☐☐☐ Date of last full set of x-rays

☐☐/☐☐/☐☐☐☐ Date of last dental appointment

What was done at that time

Name of previous dentist

Address

Reason for leaving previous dentist

Phone number

Who may we thank for referring you to our practice

Yes No

☐ ☐ Are you happy with the color of your teeth

☐ ☐ Are you happy with the appearance of your teeth

Please explain:

Are any of your teeth sensitive to:

Yes No

☐ ☐ Hot or cold

☐ ☐ Sweets

☐ ☐ Biting/Chewing

Do you use:

Yes No Times a day

☐ ☐ dental floss? ☐☐

☐ ☐ a soft toothbrush? ☐☐

☐ ☐ a waterpik? ☐☐

Yes No

☐ ☐ Do your gums bleed or hurt

☐ ☐ Do you have any loose teeth

☐ ☐ Does food ever get caught between teeth

☐ ☐ Do you bite your lips or cheek frequently

☐ ☐ Do you hold foreign objects with your teeth *(pens, pipe, etc)*

☐ ☐ Do you mouth breath while awake or asleep

☐ ☐ Do you have popping or clicking in your jaw

☐ ☐ Do you experience pain *(jaw, joint, ear, or side of face)*

☐ ☐ Do you have difficulty opening or closing your mouth

☐ ☐ Do you have difficulty chewing on either side of your mouth

☐ ☐ Do you have tired jaws, especially in the morning

☐ ☐ Do you get tension headaches

☐ ☐ Do you clench or grind your teeth while awake or asleep

☐ ☐ Have you had any teeth removed

☐ ☐ Have you had orthodontic treatment

☐ ☐ Have you had periodontal treatment

Please explain:

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Acknowledgement of Receipt of Notice of Privacy Policies

Your Privacy Is Important to Us

I have read a copy of the Notice of Privacy Practices of Steven C. Bunting, D.D.S. & Associates, P.C.
I hereby authorize, as indicated by my signature below, Steven C. Bunting D.D.S. & Associates, P.C. to use and to disclose my protected health information for my necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

Name

Address

Select

Patient, Parent or Guardian Signature

Date

(If Under 18, Parent or Guardian Signature Required)

Please check your preferred means on communication:

☐ Home Telephone ☐ Mobile Telephone ☐ Work Telephone

☐ You may send me an unencrypted email/text message at

☐ Other

Please list authorized persons with whom we may discuss your Protected Health Information (PHI in addition to custodial parents and legal guardians:

Name Date Add/Removed

Name Date Add/Removed

Name Date Add/Removed

Name Date Add/Removed

Notice Of Privacy Policies Are Available To Review At Our Office Or Anytime Online.

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify)

Staff Person Initials

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THESE POLICIES ARE AVAILABLE TO REVIEW AT OUR OFFICE OR ANYTIME ONLINE.

Steve C. Bunting, D.D.S. & Associates, P.C., hereafter referred to as "Practice," is committed to preserving the privacy and confidentiality of your health information. This Notice of Privacy Practices (NPP) describes how we may use and disclose your protected health information, hereafter referred to as "PHI," to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. 45 CFR§ 164.520. This Notice has been revised to conform to HIPAA's Final Rule referred to as the "Omnibus Rule" published 01/25/13. This notice replaces previous versions of the Notice and is effective 04/24/2014. You may access or obtain a copy according to the following options: 1) our website at www.designerofsmiles.com 2) contact the office and request a copy be sent to you by mail or email, 3) request a copy at the time of your next appointment.

1. USES & DISCLOSURES OF PHI. How We Use Your Information: Your PHI may be used and disclosed by our Practice's provider, administrative and or clinical staff and others outside of our Practice who are involved in your care and treatment for the purpose of providing healthcare services to you.
A) Treatment: We will use and disclose your PHI to provide, coordinate or manage your care and any related services. We may disclose PHI to others providers who may be treating you such as a specialist.
B) Payment: We will use your PHI to obtain payment for the services provided by this Practice. Foe example, if we are working with your insurance plan, we may verify eligibility or coverage for benefit determination. We may use or disclose your information so that a bill may be sent to you that may include services provided.
C) Healthcare Operations: The Practice may use or disclose, as needed, your PHI in order to support its business activities such as quality performance reviews regarding our services or the performance of our staff.
i) Business Associates: We may share your PHI with third party business associates such as answering services, transcriptionists, billing services, consultants, trainers and legal counsel. We obtain a written agreement with business associates to assure the protection and privacy of your PHI.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object: We may use of disclose your PHI in the following situations without your authorization or providing you the opportunity to agree or object as follows:
D) Required or Permitted by Law: We may use or disclose your PHI as required by law. This may include public health activities such as controlling a communicable disease or compliance with health oversight agencies authorized by law. We may disclose PHI to a public health authority authorized to receive reports of child abuse or neglect. We may disclose your PHI if we believe you may have been a victim of abuse, neglect or domestic violence to a governmental agency authorized to review such information in compliance with state and federal law. We may disclose your PHI to the Food and Drug Administration for the quality, safety, or effectiveness of FDA-regulated products or activities. We may disclose your PHI in the course of a legal proceeding in response to a subpoena, discovery request or other lawful process. We may also disclose PHI to law enforcement providing applicable legal requirements legal requirements are satisfied. We may disclose PHI to a coroner or medical examiner for identification purposes. We may disclose PHI to researchers when the information does not directly identify you as the source of the information and such research has been approved by an institutional review board to ensure the privacy of the PHI. We may disclose PHI as authorized to comply with workers' compensation laws. We may use and disclose your PHI if you are an inmate of a correctional facility and this information is necessary for care.

Authorization for Other Uses and Disclosures of PHI: Use and disclosure of your PHI not addressed in this Notice of Privacy Practices will be made only with your written authorization. You may revoke this authorization in writing at any time. If you revoke this authorization, we will no longer use or disclose your PHI; however, we are unable to retrieve previous disclosures made with you prior authorization.

Other Permitted and Required Uses and Disclosures that Require Your Permission or Objection:
i) Students: We may share PHI with students working in our Practice to fulfill their educational requirements. If you do not wish a student to observe or participate in your care, please notify your provider.
ii) Appointment Reminders: We may contact you as a reminder of your appointment. Only limited information is provided on an answering machine or an individual other than you answering the call. We may issue a post card or letter notifying you that it is time to make an appointment. You may provide a preferred means of contact such as a mobile telephone number or email address. Reasonable requests will be accommodated.
iii) Family, Close Friends, Personal Representatives & Care Givers: Our staff may disclose to person involved in your care your PHI relevant to that person's involvement in your care or payment of the services providing you identify these individual(s) and authorize the release of information. If you are unable to agree or object to such disclosure, we may disclosure such information as necessary if we determine

Notice of Privacy Practices (con't.)

that it is in your best interest based on our professional judgment. If a young adult age eighteen (18) requests that his or her information not be released to a parent or guardian, we must comply with this request in compliance with state law. For minor children living in divided households, both parents (mother and father) have access to the PHI unless their parental rights have been terminated. Payment of services is addressed in your Final Divorce Decree; however, we obtain payment from the parent who brings the child in for treatment. We will provide you with a statement to send to the other parent for your reimbursement.
iv) Disaster Relief: If applicable, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your care.

2. YOUR RIGHTS. The following is a statement of your rights regarding PHI we gather about you:
A) Copy of this Notice: You have the right to a copy of this notice including a paper copy.
B) Inspect and Copy PHI: You have the right to inspect and obtain a copy of PHI about you maintained by our Practice to include patient and billing records. You must submit a written request and indicate whether you prefer a paper or electronic copy. According to state and federal law, we may charge you a reasonable fee to copy our records. Our Practice does not transmit unsecure PHI via email. However, if you prefer this information emailed to you with encryption or security measures, we will comply with your request and will verify your email address. We suggest sending our Practice an email and we will reply with the attachment. (Note: Under federal law, you may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding. Please contact the Privacy Officer for more details).
C) Amendment: You have the right to have your provider amend your PHI about you in a designated record set. Please consult with the Privacy Officer. We may deny this request and you may respond with a statement. We may include a rebuttal statement in your record. Reasons we may deny amending such information, but not limited to these reasons, is if we did not create the information, or if the individual who created the information is no longer available to make the amendment or it is not part of the information maintained in our Practice.
D) Restrictions: You have the right to request a restriction of your PHI. If you paid out-of-pocket for a service or item, you have the right to request that information not be disclosed to a health plan for purposes of payment or health care operations and we are required to honor that request. You may request in writing to our Privacy Officer not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations such as to family members or friends involved in your care or for notification purposes as described in this Notice of Privacy Practices. However, your provider is not required to agree to this restriction. You may discuss restrictions with the Privacy Officer.
E) Confidential Communications: You have the right to request to receive confidential communications from our Practice by alternative means or at an alternative location. For example, you may prefer our Practice to use your mobile telephone or email rather than a residential line. Please make this request in writing to the Privacy Officer. Our staff will not ask personal questions regarding your request.
F) Disclosures: You have the right to request an accounting of disclosures of your PHI including those made through a Business Associate as set forth in the CFR 45 § 164.528. The HITECH Act removed the accounting disclosures exception to the PHI to carry out treatment, payment and healthcare operations if such disclosures are made through the EHR. To request an accounting, submit your request in writing to the Privacy Officer.
G) Breach Notification: According to the HITECH Act, you have the right to be notified following a breach of unsecured PHI that affects you. "Unsecured" is information that is not secured through the use of technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the PHI unusable, unreadable and undecipherable to unauthorized users. Breach notification applies to our Business Associates who are obligated to notify our Practice if a breach of unsecured PHI occurs that affects you.
H) Fundraising: If PHI is used for fundraising which is considered "health care operations," basic requirements must be satisfied to include notice to you and a process for you to opt-out. If the individual consents, only specific parts of the PHI may be used for fundraising. Note: Your PHI will not be used in this manner.

3. COMPLAINTS. You have the right to file a complaint if you believe your privacy rights or that of another individuals' have been violated. You may contact our Privacy Officer and your issue will be addressed. You may also files a complaint with the Secretary of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, SW, Washington, D.C. 20201. Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail; name the covered entity or business associate involved and describe the acts or omissions you believe violated the requirements of the Privacy, Security, or Breach Notification Rules; and be files within 180 days of when you knew that the act occurred. Visit the Office of Civil Rights website at www.hhs.gov/ocr/hipaa/ for more information.

If you have any questions, would like additional information or want to report a problem regarding the handling of your PHI, you may contact the Privacy Officer at:

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Huntingdon Valley, PA 19006
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You will not be penalized for filing a complaint.

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Financial Policy

Thank you for choosing The Center for Aesthetic & Restorative Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover
- Convenient monthly payment option* from Care Credit or Lending Club

Payment is required at the time services are rendered.

For patients with dental insurance, we are happy to submit claims to your insurance carrier electronically to ensure your reimbursement is sent to you quickly.

The office policy requires 48 hours notice to cancel an appointment to avoid a cancellation fee of $50.00.

There is a $30.00 charge for returned checks.

Any outstanding balance over 60 days will incur a 1.5% interest charge added monthly.

If you have any questions, please do not hesitate to ask.
We are here to help you with your dental needs.

Patient Name (please print)

Patient, Parent or Guardian Signature

Date

(If Under 18, Parent or Guardian Signature Required)

*subject to credit approval