





# GREEN HILLS DENTISTRY

FAMILY ■ COSMETIC ■ SLEEP SOLUTIONS

1150 Glenlivet Drive, Suite C38, Allentown, PA 18106 Phone: 610.395.0980 Fax: 484.223.1933 www.ghdentistry.com

## Dental Questionnaire

### Reasons for this Initial Visit

1. What is your chief reason for making this appointment? \_\_\_\_\_
2. Who may we thank for referring you? \_\_\_\_\_
3. What specific things would you like us to pay special attention to? \_\_\_\_\_

### History of Dental Care

1. When was your last visit to the dentist? \_\_\_\_\_
2. What was the reason for that visit? \_\_\_\_\_
3. Have you ever had a full series of 18 dental x-rays? Yes/no  
When \_\_\_\_\_
4. Have you ever been diagnosed with gum disease? Yes/no
5. Do your gums bleed when you brush or floss? Yes/no
6. Are you missing any teeth? Yes/no  
If so, have they been replaced? Yes/no
7. Have you ever had:
  - Gum surgery Yes/no
  - Root canal therapy Yes/no
  - Crown (caps) or bridge work Yes/no
  - Orthodontics Yes/no
  - Dental implants Yes/no
  - Full or partial removable dentures Yes/no

Comments: \_\_\_\_\_

### Screening for Jaw and Bite Problems

1. Do you have frequent headaches? Yes/no  
When (morning, evening, no pattern...) \_\_\_\_\_  
How often \_\_\_\_\_
2. Does your jaw click or get locked when you open or close? Yes/no
3. Do you have pain or tenderness in your jaw joint? Yes/no
4. Do you take pain medications including Aspirin or Ibuprofen? Yes/no  
How much \_\_\_\_\_  
How often \_\_\_\_\_
5. Do you clench or grind your teeth or ever been told you do? Yes/no
6. Have you noticed any of the following:
  - Tooth wear Yes/no
  - Gum recession Yes/no
  - Loose teeth Yes/no
7. Do you have a history of fractured teeth and/or fillings? Yes/no
8. Are your teeth sensitive to cold, heat or sweets? Yes/no
9. Have you ever been diagnosed with "TMJ" problems? Yes/no
10. Do you snore? Yes/no
11. Do you tire easily? Yes/no
12. Have you ever been diagnosed with Sleep Apnea? Yes/no
13. Have you ever been prescribed a CPAP machine? Yes/no

### Esthetic Concerns

1. Are you happy with the way your teeth look? Yes/no
2. Do you like your smile? Yes/no
3. Would you like your teeth to be whiter? Yes/no
4. What would you change about your smile if could? \_\_\_\_\_



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## Medical History

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_

Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_

Are you on a special diet?  Yes  No

Do you use tobacco?  Yes  No

Do you use controlled substances?  Yes  No

Women: Are you

Pregnant/Trying to get pregnant?  Nursing?

Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Sulfa Drugs

Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Shingles
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Angina	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Heart Pace Maker	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Herpes	<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Yellow Jaundice
		<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Rheumatism	

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

\_\_\_\_\_

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_



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## Policies and Procedures

**Welcome to Green Hills Family & Cosmetic Dentistry!** Our mission is to deliver world class dental care with a keen focus on patient service. We respect your trust in our ability to help you protect your dental health, and improve your smile. We are confident that you will feel comfortable with our caring professional staff, and state of the art facility. What follows is a brief summary of our practice policies and procedures. If you have any questions or need further clarification, we will be happy to accommodate you. Thank you again for letting us earn your trust. We work hard to exceed your expectations.

### Appointments

Initials \_\_\_\_\_

We see patients by appointment only, and are pleased to offer extended office hours. If you must change an appointment, please notify us more than **24 hours** in advance. This will allow us to offer that reserved time to another patient who needs treatment. Appointments that are missed without notice or canceled in less than 24 hours will incur a fee based on the total time of the scheduled appointment. The fee will be \$40 for every hour that reserved for that appointment.

### Emergency Care

Initials \_\_\_\_\_

If you should have an emergency, please call the office as early in the day as possible so we may see you promptly. If the office is closed, we can be reached via our paging system on our voice mail.

### Financial Policy

Initials \_\_\_\_\_

Payment is due at the time of service. If you have dental insurance, we will submit an electronic claim to your carrier so that you can be reimbursed quickly and efficiently. If you prefer to pay for your treatment in installments, please ask about our interest-free financing programs. Our flexible payment options assure that you can afford to have the care you want.

Accounts unpaid after 30 days from the date of billing are subject to a finance charge of 1.5% per month on the balance due. If your account needs to be referred to collections, you will be responsible for the cost of collection, as well as any court costs and reasonable attorney's fees.

For your convenience, if the person responsible for the patient's account payments will not be present at the time of their appointments, we will be happy to keep a current credit card number on file.

### Acknowledgement of Receipt

Initials \_\_\_\_\_

I acknowledge that I viewed a copy of Greens Hills Family & Cosmetic Dentistry **NOTICE OF PRIVACY PRACTICES.**

### Please let us know how you would like to be contacted (check all that apply)\*:

\*Our patients like our email and text appointment reminders!

Home Phone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

Text: \_\_\_\_\_

I have read and accept the Policies and Procedures of Green Hills Family & Cosmetic Dentistry as outlined above.

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# NOTICE OF PRIVACY PRACTICES

Green Hills Family & Cosmetic Dentistry, P.C., 1150 Glenlivet Drive, Suite C38 , Allentown, PA 18106  
Phone: 610.395.0980, FAX: 484.223.1933

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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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

## TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons we usually will not ask you for special written permission.

## USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- ~ When a state or federal law mandates that certain health information be reported for a specific purpose;
- ~ For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- ~ Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- ~ Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- ~ Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- ~ Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- ~ Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- ~ Uses or disclosures for health related research;
- ~ Uses and disclosures to prevent a serious threat to health or safety;
- ~ Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- ~ Disclosures of de-identified information;
- ~ Disclosures relating to worker's compensation programs;
- ~ Disclosures of a "limited data set" for research, public health, or health care operations;
- ~ Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- ~ Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

## APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

## OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

(OVER)

**(CONTINUED FROM FRONT)**

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

**YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

The law gives you many rights regarding your health information. You can:

~ Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.

~ Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

~ Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

~ Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

~ Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

~ Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

**OUR NOTICE OF PRIVACY PRACTICES**

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

**COMPLAINTS**

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

**FOR MORE INFORMATION**

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

**ACKNOWLEDGEMENT OF RECEIPT**

I acknowledge that I received a copy of Green Hills Family & Cosmetic Dentistry, P.C. Notice of Privacy Practices.

Patient name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_