☙ MEDICAL HISTORY ❧
All information will be held in strict confidence.

Patient's Name ______________________ Birthdate ______________

Primary Care Physician ______________________ City ____________ Physician's Phone (______)______________

List the **MEDICAL SPECIALISTS** you have seen

Physician's Name	Specialty	Physician's Name	Specialty

DESCRIBE YOUR OVERALL HEALTH: ☐ Outstanding (better than most people my age) ☐ Good (I don't know of any medical problem)
☐ Fair (I have some health problems but they're under control) ☐ Guarded (I have some current health problems) ☐ Poor (I have some major health problems)

WHEN WAS THE LAST TIME YOU SAW YOUR PHYSICIAN? __________(year) What was the purpose? ______________________
HAVE YOU EVER BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS? ☐ No ☐ Yes, describe ______________________

HABITS

Cigarettes ☐ Never smoked ☐ Smoked but quit. When? __________ ☐ Currently smoking. Amount? __________ Start date ________
☐ Cigars or ☐ Pipe: ☐ Never smoked ☐ Smoked but quit. When? __________ ☐ Currently smoking. Amount? __________ Start date ________
Smokeless tobacco: ☐ Never smoked ☐ Used, but quit. When? __________ ☐ Currently using. Amount? __________ Start date ________
Have you tried to quit? ☐N/A ☐ No ☐ Yes How many times? ______ What technique did you use? ☐ Abstain ☐ Nicotine patches ☐ Nicotine gum ☐ Hypnosis

Alcohol Consumption: ☐ Total abstinence ☐ Other, describe frequency & amount ______________________

Do you use any recreational drugs? ☐ No ☐ Yes

WOMEN
Are you pregnant? ☐ No ☐ Yes, estimated due date ______________ Are you nursing? ☐ No ☐ Yes
Are you taking oral contraceptives? ☐ No ☐ Yes Are you undergoing hormone replacement therapy? ☐ No ☐ Yes
Are you under treatment for osteoporosis and taking a class of medications call BISPHOSPHONATES? ☐ No ☐ Yes, which one ______________
(Some [BUT NOT ALL] common names include Actonel®, Boniva®, Fosamax®, Fosamax Plus D®, Skelid® & Didronel®)

ALLERGIES: Are you allergic to any of the following? ☐ Check here, if no known allergies

☐ Latex ☐ Penicillin ☐ Sulfa ☐ Other antibiotics ☐ Codeine ☐ Local anesthetic ☐ Aspirin ☐ NSAIDs like Motrin® ☐ Metals ☐ Other __________
Name the specific medication and describe your reaction:

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

Y N

HEART/VASCULAR
☐ ☐ Heart attack (MI)
☐ ☐ Congenital heart defect
☐ ☐ Rheumatic Fever
☐ ☐ Irregular heartbeat (missed beats)
☐ ☐ Heart murmur
☐ ☐ High blood pressure
☐ ☐ Low blood pressure
☐ ☐ Angina / Chest pains
☐ ☐ Mitral Valve Prolapse
☐ ☐ Artificial heart valve(s)
☐ ☐ Pacemaker
☐ ☐ By-pass surgery
☐ ☐ Stent placement
☐ ☐ Congestive heart failure
☐ ☐ Swelling of ankles
☐ ☐ Shortness of breath
☐ ☐ Other heart disease

BLOOD
☐ ☐ Anemia
☐ ☐ Sickle cell disease
☐ ☐ Hemophilia
☐ ☐ Bruise very easily
☐ ☐ Prolonged bleeding
☐ ☐ HIV / AIDS

Y N

RESPIRATORY
☐ ☐ Tuberculosis
☐ ☐ Emphysema
☐ ☐ Asthma
☐ ☐ Persistent cough
☐ ☐ Coughing up blood/sputum
☐ ☐ Difficulty breathing while lying down
☐ ☐ Winded going up 1 flight of stairs
☐ ☐ Lung cancer
☐ ☐ Other lung disease

BONE
☐ ☐ Arthritis / Rheumatism
☐ ☐ Osteoporosis
☐ ☐ Gout
☐ ☐ Artificial joints or limbs

URINARY
☐ ☐ Kidney disease
☐ ☐ Renal dialysis
☐ ☐ Very frequent urination
☐ ☐ Burning on urination
☐ ☐ Blood or discharge in urine
☐ ☐ Venereal disease
☐ ☐ Genital herpes

Y N

NERVOUS SYSTEM
☐ ☐ Stroke (CVA) or TIA
☐ ☐ Severe headaches / Migraines
☐ ☐ Fainting or dizzy spells
☐ ☐ Convulsions or epilepsy
☐ ☐ Numbness or tingling

ENDOCRINE
☐ ☐ Diabetes: ☐ Type I ☐ Type II
☐ ☐ Excessive thirst
☐ ☐ Thyroid disease
☐ ☐ Hypoglycemia

MENTAL HEALTH
☐ ☐ Depression
☐ ☐ Anxiety
☐ ☐ Panic attacks
☐ ☐ Psychiatric treatment
☐ ☐ Bipolar (manic – depressive)
☐ ☐ Addiction disorders ______________
☐ ☐ Other ______________

Y N

HEAD/NECK/EYES
☐ ☐ Glaucoma
☐ ☐ Macular Degeneration
☐ ☐ Loss of hearing
☐ ☐ Tonsillitis
☐ ☐ Sinus problems

DIGESTIVE SYSTEM
☐ ☐ Hepatitis, Type ____
☐ ☐ Gastric reflux
☐ ☐ Ulcers
☐ ☐ Frequent diarrhea
☐ ☐ Crohn's dis. or colitis

CANCER
☐ ☐ Tumor ____________
☐ ☐ Radiation treatment
☐ ☐ Chemotherapy
☐ ☐ Organ removal

☐ ☐ ORGAN TRANSPLANT

DOCTOR'S NOTES

TO THE BEST OF MY KNOWLEDGE, ALL THE ABOVE INFORMATION IS CORRECT.

Signed ______________________ Date ______________

21 X 13

Patient's Name ____________________

List any surgeries or major health events	
Year	Event

Medications INCLUDING over-the-counter medications and herbal supplements		
Name of medicine	Dosage	Purpose: Why are you taking it?

MEDICAL HISTORY UPDATES

❶ ____/____/____ Month Day Year BP: ____/____ ☐ R arm ☐ L arm

☐ Y ☐ N Change in health? ____________
☐ Y ☐ N Under MD's care? ☐ Y ☐ N Rx change?
☐ Y ☐ N New allergies? Tobacco? ☐ N/A ☐ Same ☐ Started ☐ Quit ____
☐ Y ☐ N Pregnant? EDD ________ ☐ Y ☐ N Nursing?

Antibiotic prophy? ☐ N/A ☐ Taken as directed ____________

I ATTEST THAT I HAVE REVIEWED MY MEDICAL HISTORY & IT IS ACCURATE, AS AMENDED. ____________

Reviewed by

❷ ____/____/____ Month Day Year BP: ____/____ ☐ R arm ☐ L arm

☐ Y ☐ N Change in health? ____________
☐ Y ☐ N Under MD's care? ☐ Y ☐ N Rx change?
☐ Y ☐ N New allergies? Tobacco? ☐ N/A ☐ Same ☐ Started ☐ Quit ____
☐ Y ☐ N Pregnant? EDD ________ ☐ Y ☐ N Nursing?

Antibiotic prophy? ☐ N/A ☐ Taken as directed ____________

I ATTEST THAT I HAVE REVIEWED MY MEDICAL HISTORY & IT IS ACCURATE, AS AMENDED. ____________

Reviewed by

❸ ____/____/____ Month Day Year BP: ____/____ ☐ R arm ☐ L arm

☐ Y ☐ N Change in health? ____________
☐ Y ☐ N Under MD's care? ☐ Y ☐ N Rx change?
☐ Y ☐ N New allergies? Tobacco? ☐ N/A ☐ Same ☐ Started ☐ Quit ____
☐ Y ☐ N Pregnant? EDD ________ ☐ Y ☐ N Nursing?

Antibiotic prophy? ☐ N/A ☐ Taken as directed ____________

I ATTEST THAT I HAVE REVIEWED MY MEDICAL HISTORY & IT IS ACCURATE, AS AMENDED. ____________

Reviewed by

❹ ____/____/____ Month Day Year BP: ____/____ ☐ R arm ☐ L arm

☐ Y ☐ N Change in health? ____________
☐ Y ☐ N Under MD's care? ☐ Y ☐ N Rx change?
☐ Y ☐ N New allergies? Tobacco? ☐ N/A ☐ Same ☐ Started ☐ Quit ____
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☐ Y ☐ N Under MD's care? ☐ Y ☐ N Rx change?
☐ Y ☐ N New allergies? Tobacco? ☐ N/A ☐ Same ☐ Started ☐ Quit ____
☐ Y ☐ N Pregnant? EDD ________ ☐ Y ☐ N Nursing?

Antibiotic prophy? ☐ N/A ☐ Taken as directed ____________

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Reviewed by

❻ ____/____/____ Month Day Year BP: ____/____ ☐ R arm ☐ L arm

☐ Y ☐ N Change in health? ____________
☐ Y ☐ N Under MD's care? ☐ Y ☐ N Rx change?
☐ Y ☐ N New allergies? Tobacco? ☐ N/A ☐ Same ☐ Started ☐ Quit ____
☐ Y ☐ N Pregnant? EDD ________ ☐ Y ☐ N Nursing?

Antibiotic prophy? ☐ N/A ☐ Taken as directed ____________

I ATTEST THAT I HAVE REVIEWED MY MEDICAL HISTORY & IT IS ACCURATE, AS AMENDED. ____________

Reviewed by

CHALFONT DENTAL CARE, P.C.
Dr. Varvara Clark, D.D.S.
8 Meadowbrook Lane
Chalfont, PA 18914
(215)822-6234
Chalfontdentalcare@verizon.net

PATIENT INFORMATION

Patient Name: ______________________________ Date: ______________
SSN: ______________ Birth Date: ______________ Gender: __________ Marital Status: ____________
Address: ____
Home Phone # ______________ Cell Phone # ______________ Work Phone# ______________

DENTAL HISTORY

Date of Last Dental Visit: ______________ Reason for this Visit: ______________
Previous Dental Practice: ______________ Phone # ______________
Have you ever had any complications following dental treatment? ________ YES ________ NO
If yes, please explain: ____

REFERRAL INFORMATION

How did you hear of our practice?: _____ Patient _____ Google _____ Website _____ Insurance Co. _____ Other
Name of Patient, Insurance Co. or "Other" Referring You to Our Practice: ______________

FINANCIALLY RESPONSIBLE PARTY INFORMATION

Name: ______________________________ Self ______ Spouse ______ Parent/Guardian ______
SSN: _________ Birth Date: _________ Home Phone# __________ Cell Phone# ___________ Work# _________
Address: ____
Employer Name: ______________________________ Occupation: ______________
Employer Address: ____

DENTAL INSURANCE INFORMATION

Primary
Name of Insured: ______________________________ Is Insured a Patient?: ____ YES ____ NO
Patient's Relationship to Insured: ______ Self ______ Spouse ______ Child _____ Other
Insured's Birth Date: ____________ Insured's Address: ______________________________
Dental Insurance Co. Name and Address: ______________________________
Dental Insurance ID# ______________ Group Plan Name ______________________ Group # ____________

Secondary
Name of Insured: ______________________________ Is Insured a Patient?: ____ YES ____ NO
Patient's Relationship to Insured: ______ Self ______ Spouse ______ Child _____ Other
Insured's Birth Date: ____________ Insured's Address: ______________________________
Dental Insurance Co. Name and Address: ______________________________
Dental Insurance ID# ______________ Group Plan Name ______________________ Group # ____________

CONSENT FOR SERVICES AND OFFICE POLICIES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

PAYMENT is expected at the time of service. **Cash, MasterCard, Visa, and Personal Checks** are accepted. Accounts outstanding more than 30 days from treatment date will incur a **$35 LATE FEE**.

TREATMENT ESTIMATES for dental care can only be extended for a period of six months from the date of the patient examination.

If you have **DENTAL INSURANCE**, we will help you to determine the coverage you have available. As a courtesy, we will file your insurance forms, which will save you considerable time and trouble. ***We accept payments from most PPO dental insurance companies***, which reduces your immediate out-of-pocket expense. Please keep in mind that your insurance plan may not cover what is deemed medically necessary. Insurance is intended to mitigate costs of dental treatment. We cannot control what is or is not covered, as that is established by your employer and/or plan selection. ***You will be financially responsible for the total treatment fee.***
(Regardless of what we may calculate your insurance company to pay, it is only an estimate. Our estimate is based on limited information obtained from your insurance company. We cannot forecast what they will pay. We do require that all deductibles and co-payments be paid in full at the time of service. In addition, all out-of-pocket payments for non-covered services and non-insureds are expected to be paid in full at the time of service.)

Patients are seen by appointment only. We make every effort to be on time for our patients and ask that you extend the same courtesy to us. ***We reserve the right to charge $50.00*** for **APPOINTMENTS** ***canceled or broken without 24 hours notice.***

I have read the above conditions of treatment and payment and agree to their content.

Patient/Guardian Name (printed)____

Patient/Guardian Signature____________________________________**Date**______________

CHALFONT DENTAL CARE, P.C.
Dr. Varvara Clark, D.D.S.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO FAMILY MEMBERS AND FRIENDS

Patient Name ______________________________________ **Date of Birth** ____/____/____

I hereby authorize Chalfont Dental Care, P.C. to release my patient health information as described below:

Release to:

Name________________________________ Relationship______________________________

Name________________________________ Relationship______________________________

Name________________________________ Relationship______________________________

Type of Information allowed to disclose: (please check all that apply)

Medical Treatment/Diagnosis______
Billing Information______

Method of Disclosure: (please check all that apply)

By Phone______ Phone Number of above Mentioned Family Member____________________
In Person______

Patient Signature____Date________________

CHALFONT DENTAL CARE, P.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effective **September 21, 2015**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Appointment Reminders. We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Michele Krzaczyk

Telephone: (215)822-6234 Fax: (215)822-6373

Address: 8 Meadowbrook Lane, Chalfont , PA 18914

E-mail: Chalfontdentalcare@verizon.net

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CHALFONT DENTAL CARE, P.C.
Dr. Varvara Clark, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

---

* You May Refuse to Sign This Acknowledgment*

I, ________________________________ have received a copy of this office's Notice of Privacy Practices.

Print Name:________________________________

Signature:________________________________

Date:________________________________

For Office Use Only

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

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify)________________________________

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CHALFONT DENTAL CARE, P.C.
Dr. Varvara Clark, D.D.S.

CONSENT FOR ELECTRONIC COMMUNICATIONS/SOCIAL MEDIA SURVEY/PHOTOS

Patient Name: ____ Date of Birth: ______________

I agree that the above mentioned dental practice may communicate with me electronically at the email address indicated below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

EMAIL ADDRESS:________________________________@____________________________

I can withdraw my consent to electronic communications by calling (215)822-6234 or emailing at ChalfontDentalCare@Verizon.net.

Are you on **FACEBOOK? Yes______ No______** (**LIKE** us on Facebook: **https://www.facebook.com/chalfontdentalcare)**

Are you on **INSTAGRAM? Yes______ No______** (**FOLLOW** us on Instagram: **#chalfontdentalcare)**

Would you be willing to post a review on any social media outlet or review website? (e.g. Google, Yelp, FaceBook)

Yes______No______

I hereby consent to the taking of x-rays, photographs and other necessary records before, during and after dental treatment for dental records, dental education and marketing purposes to be used on websites and social media. I further understand that if the photographs and/or videos are used, I will not be compensated, financial or otherwise, for the use of these photographs.

Patient Signature:____ Date: ______________