A-Plus Dental Care

Patient Information and Registration

General Information

Patient's Name _____ DOB _____ SSN _____
First MI Last

Name of Spouse or if Child, Name of Parent(s) ☐ Male ☐ Female ☐ Single ☐ Married ☐ Minor

_____ _____
First MI Last First MI Last

Mailing address: _____ City/Town _____

State, Zip _____ Phone(H) _____ (W) _____ Email: _____

Employer's name and address: _____

Who is responsible for payment not covered by insurance? _____

Medical History

yes	no		yes	no		yes	no	
☐	☐	Allergies to anesthetics	☐	☐	Stroke	☐	☐	Cancer
☐	☐	Any heart problem	☐	☐	Heart problem	☐	☐	Eye disordrs
☐	☐	High blood pressure	☐	☐	Thyroid problem	☐	☐	Tonsillitis
☐	☐	Neurological problems	☐	☐	Disbetes	☐	☐	Tuberculosis
☐	☐	Radiation treatments	☐	☐	Kidney problems	☐	☐	Ulcer or Colitis
☐	☐	Excessive bleeding from cut	☐	☐	Liver problems	☐	☐	Pregnancy; If yes, Due_____
☐	☐	Anemia or blood problem	☐	☐	Emphysema	☐	☐	Asthma or breathing problem
☐	☐	Joint replacement/implant	☐	☐	Any major operation	☐	☐	Hay fever or allergies in generl
☐	☐	Psychiatric care, depression	☐	☐	Arthritis	☐	☐	Venereal Disease
☐	☐	Heart murmur	☐	☐	Rheumatic fever	☐	☐	Other _____
☐	☐	MVP, MIT	☐	☐	Sinus problems	☐	☐	Allergy to: __Penicillin, __ Motrin, __ Sulfa
☐	☐	Pace make	☐	☐	Aids, HIV, Herpes	☐	☐	To other Med:

Your physician's Name _____ Phone _____

Date of last visit to your doctor _____ Purpose of visit _____

Have you ever, or do you now take illegal drugs _____ If yes, what _____

Are you taking any medication _____ If yes, what _____

Dental History

yes	no		yes	no		yes	no	
☐	☐	Teeth sensitive to cold, hot, etc	☐	☐	Food impaction	☐	☐	Oral habits, i.e. sucking finger
☐	☐	Bleeding gums when brushing	☐	☐	Oral cancer, tumor	☐	☐	Smoking, long _____
☐	☐	Unusual sounds in jaw joint	☐	☐	Bad breath	☐	☐	type, quantity _____
☐	☐	Clenching or grinding teeth	☐	☐	Using dental floss	☐	☐	Allergies to dental anesthesia
☐	☐	Burning of tongue, mucosa	☐	☐	Pain around ear	☐	☐	Using inter dental stimulators
☐	☐	Swelling of lumps in mouth	☐	☐	Periodontal treatment	☐	☐	Using mouth rinsing
☐	☐	Complications from extraction	☐	☐	Orthodontic treatment	☐	☐	Fluoride supplements

Date of last visit of your dentist _____ Where _____

Note: A change in your health status should be reported to the office at your earliest possible time.

To the best of my knowledge, the foregoing questions have been accurately answered;

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers, and/or other health practitioners.

Person completing the form: Signature _____ Print Name _____

If other than patient, indicate relationship _____ Date _____

Patient's Name _____ DOB _____
First Mi Last

How did know about our clinic? Insurance Dir. ___ Ad. ___ Sign ___ Yellow Pages ___ Patient/Friend _____
Name

Dental Insurance 1

Dental Insurance Company: _____ Insurance Company Phone #: _____
Policy Owner's Name: _____ Policy Owner's DOB: _____
Insurance ID # or SSN: _____ Group #: _____
Relationship to Patient: _____
Insurance Company Address: _____
Tel #: _____
Please presentinsurance card to front desk.

Dental Insurance 2 (if any)

Dental Insurance Company: _____ Insurance Company Phone #: _____
Policy Owner's Name: _____ Policy Owner's DOB: _____
Insurance ID # or SSN: _____ Group #: _____
Relationship to Patient: _____
Insurance Company Address: _____
Tel #: _____
Please presentinsurance card to front desk.

I certify that I have provided ALL insurance information. Federal and state law requires that this office from insurance carriers in a specific order.

I certify that I will notify this office of any update of this information.

I hereby authorize a request the performance of dental services for the patient.

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his/her supervised staff for diagnostic purposes of dental treatment.

I understand that I am responsible for payment of any denial of coverage due to failure to disclose use of benefits at another office.

I understand the PAYMENT IN FULL is due at time of service by credit card, cash or verified insurance coverage.

I understand that a missed appointmentcharge will apply for appointments missed with less than one business day notice before appointment.

I have all of my question answered.

Signature of responsible party _____ Date _____

STUFF USE ONLY: Dentist's Medical History review & Significant Findings

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Doctor Signature _____ Date _____

A-Plus Dental Care

Acknowledgement of Receipt of Notice of Privacy Practices

Your May Refuse to Sign This Acknowledgement

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

Please Print Your 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:

□ Individual refused to sign

□ Communications barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (please specify)

_____

_____

_____

A-Plus Dental Care

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.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 02/01/2003, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

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

PATIENT RIGHTS Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.39 for each page, $19 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

Contact Officers: Hongmei Yang, D.M.D and Yang Chen, D.M.D
Telephone: (610) 594-2000 Fax: (610) 594-2005
E-mail: aplusdentistry@gmail.com
Address: 356 N. Pottstown Pike, Suite 100, Exton, PA 19341

A-Plus Dental Care

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Exton, PA 19341

Financial Responsibility Policy

As a result of the many different and confusing insurance company reimbursement policies, it is necessary to have an easily understood financial responsibility policy.

1. It is important for you to provide the office with complete insurance information for all carriers with whom you are insured at the time of service. **At each office visit** we need you to show us your insurance card to insure that your current insurance information is on file
2. As a service to our patients, we will submit your insurance claim to your primary insurance company. Our office will provide the insurance company with all the information necessary to help you receive maximum benefit from your insurance company. However, it is the patient's responsibility to know the insurance coverage and benefits limit of their particular policy.
3. If a claim is denied, we will research why the rejection occurred an wither resubmit to insurance or bill you the appropriate balance. If the clam is denied a second time, the appropriate balance immediately becomes the responsibility of the patient and should be paid to us directly. You may then contact your insurance company for reimbursement.
4. If the patient has coverage with a second insurance company, the patient should then submit all secondary claims directly to that insurance company along with a copy of the explanation of benefits from the primary insurance.
5. Insurance is a patient's benefit designed to assist the patient in their financial obligation to Stephen Family Dentistry. The patient is the one receiving the dental service and therefore is ultimately responsible for all charge on the one receiving the dental service and therefore is ultimately responsible for all charge on the account regardless of any insurance coverage. This applies to everyone in the family who is treated by A-Plus Dental Care.
6. The office will collect the patient's deductible (when services are subject to the deductible) and the estimated balance after insurance at the time services are rendered. After Insurance payment is received the patient will be billed for any difference between the anticipated insurance payment and the actual insurance payment.
7. In the event that the patient does not have insurance coverage, charges for services are due and payable at the time services are rendered, unless prior arrangements have been approved.

Insurance benefits are estimates only. I understand that I am responsible for any co-payments and deductibles, along with any procedures that my insurance company does not cover. I authorize the dentist to release any information (X-ray, photo picture, molder, personal information etc), including diagnosis and records of treatment rendered to my family, or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier my pay less than the actual bill for services, I agree to be responsible for payment of all services rendered and any collection fees accumulated on my behalf or that of my dependents. I am also responsible for any insurance claims not paid within 60 days of service.

_____ _____

Signature of Patients (parent if minor) or Responsible Party Date