ROBERT J. MANSELL, D.M.D. & ASSOCIATES, P.C.

ROBERT J. MANSELL, D.M.D.
JOHN F. CARABELLO, D.M.D.

1047 OLD YORK ROAD • ABINGTON, PA 19001 • TELEPHONE: 215-884-1668
FAX: 215-885-9825
www.abingtonpadentist.com

WELCOME

We are pleased that you have chosen our practice, and look forward to meeting with you.

In the event that a medical/dental health history form is sent to you, please complete it at your convenience. Kindly mail, scan or fax it to us a few days prior to your appointment. If time does not permit please bring it with you the day of your appointment.

We are a general practice that offers a wide variety of dental services. Our doctors provide a wide range of care, including adult and child orthodontics, restorative, crown and bridge, periodontics, endodontics, bonding, bleaching, and implant dentistry.

Our office hours afford a level of flexibility to accommodate our patients and a handicap ramp is available for those in need.

It is our hope you will find dental treatment in our office a pleasant experience.

Yours for Better Dental Health,

Dr. Robert J. Mansell

Health History Form

ADA
American Dental Association
www.ada.org

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: (Last First Middle) | Home Phone: *Include area code* ( ) | Business/Cell Phone: *Include area code* ( )

Address: (Mailing address) | City: | State: | Zip:

Occupation: | Height: | Weight: | Date of birth: | Sex: M F

SS# or Patient ID: | Emergency Contact: | Relationship: | Home Phone: ( ) | Cell Phone: ( ) *Include area codes*

If you are completing this form for another person, what is your relationship to that person?

Your Name | Relationship

Do you have any of the following diseases or problems: ***(Check DK if you Don't Know the answer to the question)***

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink In a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation: _____ Phone: _____

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

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INSURANCE/FINANCIAL POLICY

Revised January 2014

PLEASE READ CAREFULLY

Thank you for choosing our practice. Our primary concern is your health and comfort, but it does come at a cost to all of us. As a courtesy to you, our office will be glad to prepare and submit your insurance claims, provided we have the correct information. We will do all we can to help you receive the maximum benefits so that you can receive the care that you need. Please keep in mind that there is no guarantee of payment from your insurance company. However, we can get a pre-determined estimate for the work that you require so that you can be better prepared to meet your financial obligations. In most instances, insurance will not cover the entire cost of your dental procedures. If you have insurance that might cover your care, you must supply us with your insurance ID card, policy and group number for correct processing. We hope this clears up any questions that you might have regarding our insurance policy, but if there ever is an issue, please ask us and we will be happy to assist you. We look forward to meeting you, and taking care of all your dental needs.

Dr. Robert J. Mansell D.M.D. & Associates, P.C.

Received by:_____

Date:_____

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Acknowledgement of Receipts of Forms

I have received the Privacy Policies of Robert J. Mansell D.M.D. and Associates and have been provided an opportunity to review it at my leisure.

_____ _____

(Patient Signature) *(Date)*

Patient Record of Disclosures

In general, the HIPAA privacy rule gives the individual the right to request restriction of uses and disclosures of the protected health information (PHI) for the purpose of continuity of my care or to adjudicate my account. The authorization does not take the place of our standard record release authorization.

I authorize my PHI to be disclosed to the following individuals: _____
(Patient Signature)

Spouse _____ Adult Child _____
(Name) *(Name)*

Other _____ _____
(Name) *(Name)*

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to any authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided to us and documented in our health record database will constitute an adequate record.

Note: Uses and disclosures for treatment may be permitted without prior consent in an emergency.

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NOTICE OF PRIVACY PRACTICES

Revised January 2014

This notice details how *Robert J. Mansell D.M.D. & Associates* collects, handles, and protects our patients' personal, medical and financial information, and reflects the content of our HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Policy.

Use and/or Disclosure of PHI (Protected Health Information)

- Routine uses:
  - Treatment, scheduling, payment and operations
  - Patient or designated representative request
  - Insurance company audit/claim adjudication
  - Legal pursuit
- Disclosure without authorization is permitted:
  - As required by law
  - For public health activities
  - For victims of abuse, neglect, or domestic violence
  - For health oversight activities
  - For judicial and administration proceedings
  - For law enforcement purposes
  - For decedents
  - For cadaveric organ, eye, and tissue donation purposes
  - For research purposes
  - To advert a serious threat to health or safety
  - For specialized government functions
  - For disability documentation
  - For workers compensation
- PHI will only be released with written consent from the patient or parent/guardian of the minor patient, unless noted above for disclosure without authorization.

Safeguards for the Protection of PHI:

- Patient records are stored in a secure data base in accordance with the administrative, physical, and technical safeguards of the HIPAA Security Rule.

Patients' Rights:

- Our patients have the right to privacy and respect regarding their personal information.
- The patient has a right to inspect and copy health records with reasonable notice.
- The patient has the right to *request* amendment or correction.
- The patient has the right to an accounting of disclosures.
- The patient has the right to specify how confidential information is communicated.
- The patient has the right to request a restriction on how health information is disclosed or used.
- The patient has a right to file a complaint if they believe that our safeguards and procedure have not been followed. Any privacy issue complaints should be directed to the Privacy Officer of Robert J. Mansell D.M.D. & Associates, or to any manager. If satisfaction is not received, the patient may notify the Department of Health & Human Services.

Patient Consent

1. I do authorize and give consent to **Robert J. Mansel D.M.D & Associates**, the dentist and his/her staff to administer treatment, including but not limited to local anesthesia and other such treatment, which in their judgment, may be necessary for the prudent exercise of medical or dental care. I understand that the use of medications, anesthetics and some procedures embody a certain risk.

2. I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained.

3. I understand that during the procedure unforeseen conditions may arise that necessitate different procedures from those planned. I consent to the performance of additional procedures that are deemed necessary in the professional judgment the dentist and I understand that payment for these additional procedures is my responsibility.

4. The attached medical and dental history was completed fully and accurately to the best of my knowledge.

5. I understand responsibility for payment of dental services provided in this office for myself or my dependent is mine. Unless other arrangements are made prior to treatment, accounts are to be paid on the day services are provided. I have read and I understand **Robert J. Mansell D.M.D & Associates** financial policy.

6. I herby authorize payment of my group insurance benefits, otherwise payable to me, to **Robert J. Mansell D.M.D & Associates.** In the event of legal action of this account, I agree to pay any and all costs of such suit, collection and attorney fees. I have reviewed the treatment plan and authorize the release of any information relative to this claim.

7. A service charge of 1.5% per month (18% annually) will be added to the unpaid balance of all accounts not paid in full within 90 days of treatment date.

8. I grant my permission to you or your assignees to telephone me at home or at my work to discuss matters related to this consent, my treatment or my account. Phone #_____

9. I have had the opportunity to review **Robert J. Mansell D.M.D & Associates** Notice of Privacy Practices.

10. I understand that if I am unable to keep my appointment, I need to let Robert J. Mansell D.M.D & Associates know at least 24 hours in advance. **I also understand Robert J. Mansell D.M.D & Associates reserves the right to assess a minimum $25 fee for late cancellations and/or missed appointments.**

_____ _____

Patient Name (Please Print) Date

_____ _____

Signature of Patient or Responsible Party Relationship (if responsible party)