ANTHONY F. PITTELLI, D.M.D.

280 Pierce Street
Kingston, PA 18704

Date _____

Name _____ Birthdate _____ Sex _____ M _____ F _____

Single ____ Married ____ Divorced ____ Separated ____ Widowed ____

Address _____ City _____ State _____ Zip _____

Social Security #_____ Home Phone _____

Employed by_____ **Cell phone** _____

Business address _____ Phone _____

Spouse's Name _____ Spouce's Birth Date _____ S.S.#_____

Employed by _____ **e-mail address:** _____

Business address _____ Phone _____

Person responsible for payment _____

Address _____ Phone _____

Dental Insurance: _____ YES _____ NO Subscriber_____S.S.#_____

Insurance Company: _____ Employer_____ Group #_____

Address_____

Second Insurance? _____ YES _____ NO Subscriber_____ S.S. #_____

Insurance Company: _____ Employer_____ Group # _____

How did you choose our office? _____

Why are you seeking dental treatment ? _____

Are you satisfied with the appearance of your teeth? _____ YES _____ NO

If NO Explain Why _____

DENTAL HISTORY

	YES	NO
1. Are you having discomfort at this time?	☐	☐
2. Any serious trouble associated with previous dental treatment?	☐	☐
3. Does dental treatment make you nervous?	☐	☐

4. Date of last dental visit _____

5. When was last full mouth X-Rays taken? _____ where _____

	YES	NO
6. Have you ever been treated for Gum disease?	☐	☐

7. Do you have or have you had any of the following:

MOUTH	YES	NO	TEETH	YES	NO
Bleeding, sore gums	☐	☐	Loose teeth	☐	☐
Unpleasant breath	☐	☐	Sensitive to hot	☐	☐
Burning tongue/lips	☐	☐	Sensitive to cold	☐	☐
Frequent blisters, lips/mouth	☐	☐	Sensitive to sweets	☐	☐
Swelling/lumps mouth	☐	☐	Sensitive to biting	☐	☐
Clicking jaw	☐	☐	Clenching/grinding	☐	☐

(continued)

MEDICAL HISTORY

	YES	NO
1. Has there been any change in your general health in past year?	☐	☐
2. My last physical examination was on _____		
3. Are you under the care of a physician?	☐	☐
If so, what is the condition being treated _____		
4. The name and address of my physician is _____		
_____		
5. Have you had any serious illness within the last 5 years?	☐	☐
If so, what was the problem _____		
6. Have you been hospitalized or had an operation within past 5 yrs?	☐	☐
If so, what was the problem _____		

7. Do you have or have you had any of the following:

	YES	NO		YES	NO
Sinus problems	☐	☐	Heart attack/trouble	☐	☐
Stroke	☐	☐	Chest pain/discomfort	☐	☐
Headaches	☐	☐	High blood pressure	☐	☐
Convulsions/epilepsy	☐	☐	Heart murmur	☐	☐
Dizziness/fainting	☐	☐	Congenital heart disease	☐	☐
Psychiatric treatment	☐	☐	Artificial heart valve	☐	☐
Tuberculosis	☐	☐	Pacemaker	☐	☐
Emphysema	☐	☐	Heart surgery	☐	☐
Asthma/hay fever	☐	☐	Anemia	☐	☐
Diabetes	☐	☐	Rheumatic fever	☐	☐
Family history diabetes	☐	☐	Hepatitis	☐	☐
Radiation therapy	☐	☐	Ulcers	☐	☐
Tumors or growths	☐	☐	Venereal disease	☐	☐
Cancer	☐	☐	AIDS/HIV	☐	☐

8. Are you ALLERGIC or have you ever experienced any reaction to the following:

	YES	NO		YES	NO
Local anesthetics (novocaine)	☐	☐	Aspirin or codeine	☐	☐
Barbituates/sedatives	☐	☐	Sulfa drugs	☐	☐
Penicillin/antibiotics	☐	☐	Other _____		

9. Are you taking any of the following:

	YES	NO		YES	NO
Antibiotics/sulfa drugs	☐	☐	Tranquilizers	☐	☐
Blood thinners	☐	☐	Insulin	☐	☐
Blood pressure medication	☐	☐	Recreational drugs	☐	☐
Cortisone/steroids	☐	☐	Digitalis/heart medications	☐	☐
Antihistamines/allergy/cold	☐	☐	Nitroglycerin	☐	☐
Aspirin	☐	☐	Other medication _____		

WOMEN

	YES	N
Are you pregnant?	☐	☐
Are you taking birth control or hormone therapy?	☐	☐

Signature _____

Anthony F. Pittelli, D.M.D., P.C.

280 Pierce Street
Kingston, PA 18704

Phone: (570) 287-3009

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT

We now offer the following payment options:

___ Payment by cash

___ Payment by check

___ Payment by credit card

___ Automatic monthly billing to your Visa or MasterCard

___ Guarantee any amount not covered by insurance with Visa or MasterCard

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see the office manager. Thank you.

_____
Print your name here and sign below

*x*_____
Date: _____

Anthony F. Pittelli D.M.D

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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

_____
Please 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:

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

_____

_____

_____

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 April 14, 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 $0.50 for each page, $15.00 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 Officer: Liza A. Pittelli

Telephone: (570) 287-3009 Fax: (570) 287-8698

E-mail: [redacted]

Address: 280 PIERCE ST

KINGSTON PA 18704