

MAIN LINE SMILES

Simply Sensational Smiles

Prefix: _____ Name: _____

Preferred Pronouns: _____ Date of Birth: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Mailing Address: _____

Occupation: _____ Employer: _____

Work Phone: _____ Best way to contact you? _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone #: _____

Dental Insurance: _____ Group #: _____

Insurance Address: _____

Policy Holder's Name: _____ Relation to Patient: _____

Policy Holder's Date of Birth: _____ Member ID: _____

Policy Holder's Employer: _____

Previous Dentist: _____ Last Exam: _____

What is your chief dental complaint? _____

Do dental visits provoke high anxiety for you? _____

Whom may we thank for referring you? _____

I accept full responsibility for payment of all charges for dental treatment rendered.

Signature of Patient

Date

TARA SEXTON, DMD

Patient Name:

Date of Birth:

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 physicians's care now?	☐ Yes ☐ No	If yes	
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes	
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes	
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No	If yes	
Are you required to predicate for dental procedures?	☐ Yes ☐ No	If yes	
Have you ever taken medications containing bisphosphonates (to limit the loss of bone density)?	☐ Yes ☐ No	If yes	
Do you use tobacco or controlled substances?	☐ Yes ☐ No	If yes	

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 ☐ Sulfa Drugs
☐ Local Anesthetics Other?

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

AIDS/HIV Positive	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Easily Winded	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Blood Transfusions	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Breathing Problems	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No
Cortisone Medicine	☐ Yes ☐ No						

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes

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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I, _____, hereby give **consent** to Dr. Sexton to perform any or all of the following dental restorative procedures:

Crown/bridge (porcelain, porcelain and metal, resin),
Implant crowns Inlays/Onlays (resin, porcelain, metal)
Removable Appliances
Veneers (porcelain, resin)
Direct Fillings (resin, metal)
Invisalign
Bleaching

I agree to have these procedures done with the full understanding and acceptance that:

- during the procedure endodontic therapy may be necessary on one or all of the teeth being treated
- the procedure may result in a reduction of height and circumference of the tooth
- an impression may be taken with a rubbery material and a retraction cord may need to be placed below the gum around the tooth prior to the impression
- I may experience soreness in the soft tissue and bone in the area being treated as well as sensitivity in the teeth. This sensitivity may be present while the teeth are subject to temporary restorations, but may continue for an extended period of time after placement of the permanent restorations
- the temporary and permanent restoration may feel and look differently than my natural teeth (every effort will be made to match the natural dentition)
- no guarantee for lifelong results of any restoration can be given, therefore re-treatment may be needed due to periodontal disease, decay, fracture, or endodontic therapy which may result in additional costs
- refusal of any portion of the recommended treatment may jeopardize both my restorations and my entire dentition, including all supporting bone and tissue
- it is my responsibility to maintain proper oral hygiene at home and receive professional preventive care at least twice annually to maintain oral health throughout my dentition

I authorize photos, slides, x-rays or any other viewing of my care and treatment during and after its completion to be used for the advancement of dentistry and for reimbursement purposes. My identity will not be revealed to the general public without my permission.

I agree to the use of local anesthesia, sedation and/or analgesia, depending on the doctor's judgment. I understand that medications for discomfort and sedation may cause drowsiness, which can be increased by the use of alcohol or other drugs. I will avoid operating any vehicle or hazardous devices while taking such medications.

I have been fully informed of the nature of the dental restorative treatment received or to be performed, the procedure to be utilized, the risk and benefits of this procedure, the alternative treatments that may be available, the necessity for follow up and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my dentist.

Upon careful consideration of the information contained in this form and a discussion with my dentist, I hereby consent to the performance of the procedure as presented to me during consultation. I also consent to the performance of such additional or alternative procedures that may be necessary in the best judgment of my dentist.

The fees involved with these procedures have been discussed prior to treatment and I agree to pay them in full at the time of service.

I certify that I have read and fully understand this document:

Date: _____

Signature: _____

TARA SEXTON, DMD

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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 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

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to 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 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 to disclosures for health related research

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- Uses and disclosures to prevent serious threat to health or safety;
- Uses or disclosures for specialized government treatment 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 services;
- Disclosures of de-identified information
- Disclosures resulting 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. 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 email 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 email to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra costs. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or email shown at the beginning of this notice.
- Ask to see or 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

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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 photo copies 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 email 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 history 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 an 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 email 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 the purpose 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 any 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 email 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 email 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 website.

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 contact person at the address, fax or email shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

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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 have received a copy of Dr. Tara Sexton's Notice of Privacy Practices.

Patient Name_____

Patient Signature_____ **Date**_____

TARA SEXTON, DMD

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