

## PATIENT INFORMATION (CONFIDENTIAL)

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
FIRST MI LAST  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_  
E-MAIL \_\_\_\_\_ CELL PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
SS#/SIN \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED  
IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_  
PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_  
SPOUSE OR PARENT'S/GUARDIAN'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_  
PERSON TO CONTACT IN CASE OF AN EMERGENCY \_\_\_\_\_ PHONE \_\_\_\_\_

## RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
DRIVER'S LICENSE # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

## INSURANCE INFORMATION

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_ SS#/SIN \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_  
NAME OF EMPLOYER \_\_\_\_\_ UNION OR LOCAL # \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_  
INSURANCE CO. \_\_\_\_\_ TEL. # \_\_\_\_\_ GRP # \_\_\_\_\_ POLICY / I.D. # \_\_\_\_\_  
INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_  
HOW MUCH IS YOUR DEDUCTIBLE? \_\_\_\_\_ HOW MUCH HAVE YOU USED? \_\_\_\_\_ MAX ANNUAL BENEFIT? \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_ SS#/SIN \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_  
NAME OF EMPLOYER \_\_\_\_\_ UNION OR LOCAL # \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_  
INSURANCE CO. \_\_\_\_\_ TEL. # \_\_\_\_\_ GRP # \_\_\_\_\_ POLICY / I.D. # \_\_\_\_\_  
INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_  
HOW MUCH IS YOUR DEDUCTIBLE? \_\_\_\_\_ HOW MUCH HAVE YOU USED? \_\_\_\_\_ MAX ANNUAL BENEFIT? \_\_\_\_\_

X

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

PATIENT NUMBER

REGISTRATION

Patient Name:

Birth Date:

Date Created:

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 physician's care now?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> No		

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? ☐ If yes Do you use controlled substances? ☐ Yes ☐ No If yes 

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

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

Have you ever had any serious illness not listed ☐ 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:

X \_\_\_\_\_

Date: \_\_\_\_\_

**DAVID S. STRASSMAN, DDS  
1575 POND ROAD, SUITE 101  
ALLENTOWN, PA 18104**

**OFFICE FINANCIAL POLICY**

We are committed to providing you with the very best dental care, and to ensure that your care is a pleasant experience.

**DENTAL INSURANCE**

We will gladly discuss your treatment and answer any questions relating to your dental insurance providing that you give us your current dental insurance information. You must realize however, that:

1. Your Insurance is a contract between you, your employer and the insurance company.
2. Not all services are a covered benefit in all contracts. We must emphasize that our relationship is with you and not with your insurance company.
3. While the filing of your insurance claim is a courtesy that we extend to our patients, all charges are your responsibilities from the date services are rendered. We will do our best to estimate your co-pay for your services.

**NO DENTAL INSURANCE / NO DENTAL INSURANCE 65 AND OLDER**

If you do not have any Dental Insurance:

1. Payment is due at time of service.
2. We offer our patients 65 and older a senior citizen discount who do not have any dental insurance. Senior citizen discounts cannot be combined with any other discount.

**WE ACCEPT THE FOLLOWING FOR PAYMENT**

1. We accept the following cash, checks, credit cards or care credit.
2. Please note a finance charge will be apply to all balances 60 days or older.

**LATE ARRIVAL OR BROKEN APPOINTMENT FEE'S**

Patient's arriving 15 or more minutes late for a scheduled appointment, the appointment will be rescheduled and subject to a cancellation charge. All cancellations must be provided with at least 48 hours' notice or you may be charged a cancellation fee of \$55.00.

**I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT  
PERMISSION TO DISCUSS DENTAL TREATMENT**

In the event that you may want a **FAMILY MEMBER OR FRIEND** to discuss your dental treatment with our office, we must have permission/consent in writing from you to do so.

In section "**A**" please list any person you give Dr. Strassman and Staff permission/consent to discuss your information such as x-rays, account information, treatment, etc.

If you do not wish to give consent to any person, please check section "**B**" below, sign and date the bottom portion of this form.

You must choose one option.

**\*\* If the patient is a minor, we will discuss dental treatment with either parent or guardian\*\***

**A.** \_\_\_\_ I hereby give permission/consent to Dr. Strassman and Staff to discuss any and all dental information with the named individuals below.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**B.** \_\_\_\_ I do not wish Dr. Strassman and Staff to discuss any of my dental treatment with anyone other than me.

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent / Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_



# **DR. DAVID STRASSMAN**

## **NOTICE OF PRIVACY PRACTICES**

### **Protecting Your Confidential Health Information is Important to Us**

#### **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.

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#### **Our Promise**

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA-Health Insurance Portability And Accountability Act) enacted to protect the confidentiality of your health information.

We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

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#### **Why do you have a privacy policy?**

Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in health care. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it. We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient. We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting health care operations, and as otherwise described in this notice.

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#### **How your HEALTH INFORMATION may be used To Provide Treatment**

We will use your HEALTH INFORMATION within our office to provide you with dental care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing your treatment.

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#### **To Obtain Payment**

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

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#### **To Conduct Health Care Operations**

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is

also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

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#### **In Patient Reminders**

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

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#### **To Business Associates**

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

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### **NOTICE OF PRIVACY PRACTICES**

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

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#### **As Required By Law**

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

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#### **Abuse or Neglect**

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interests.

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#### **Public Health and National Security**

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

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#### **For Law Enforcement**

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

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#### **Family, Friends and Caregivers**

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best

judgement when sharing your health information only when it will be important to those participating in providing your care.

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### **Workers' Compensation Purposes**

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

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## **PROTECTING YOUR CONFIDENTIAL HEALTH INFORMATION IS IMPORTANT TO US**

### **Judicial and Administrative Proceedings**

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

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### **Incidental Uses and Disclosures**

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

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### **Health Oversight Activities**

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

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### **To Avert A Serious Threat To Health or Safety**

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

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### **To the U.S. Department of Health and Human Services (HHS)**

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

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### **For Research**

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

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### **In Connection With Your Death or Organ Donation**

We may disclose your health information to coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

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### **Authorization to Use or Disclose Health Information**

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

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## **PATIENT RIGHTS**

You have the following rights related to your health information.

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### **Restrictions**

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or health care

operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a health care item or service for which you have paid us out-of-pocket in full.

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### **Confidential Communications**

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communication.

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### **Inspect and Copy your Health Information**

You have a right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

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### **Amend Your Health Information**

You have a right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

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### **Accounting of Disclosures of Your Health Information**

You have a right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

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### **Request a Paper Copy of this Notice**

You have a right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

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## **PATIENT ACKNOWLEDGEMENT**

Patient

Name: \_\_\_\_\_

Patient

Signature: \_\_\_\_\_

Date: \_\_\_\_\_