PROSTHODONTICS
LIMITED
ARTISTRY IN EVERY SMILE
COMPLEX RESTORATIVE DENTAL CARE AND IMPLANT DENTISTRY
SINCE 1979

Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Other ☐ Married ☐ Single ☐ Child ☐ Other: _____

Social Security #: _____ Birth Date: _____ Email: _____

Phone (Home): _____ (Mobile): _____ Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime ☐M ☐T ☐W ☐T

Address: _____
Street Apartment #

_____
City State Zip Code

Name of nearest relative not living with you: _____ Relationship: _____

Health Information

Have you ever had or do you have any of the following? Please check those that apply:

☐ Adenoid Problems
☐ Adrenal Problems
☐ Allergies: _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Back or Spinal Problems
☐ Blood Disease
☐ Cancer: _____
☐ COPD
☐ Diabetes; Type: I / II
☐ Dizziness or Vertigo
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Fibromyalgia
☐ Glaucoma
☐ Growths
☐ Head Injuries
☐ Heart Disease
☐ Heart Attack (MI)
☐ Heart Murmur
☐ Hepatitis
☐ Infectious Disease
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous System Disorders
☐ Pacemaker
☐ Pregnancy
☐ Radiation Treatment
☐ Respiratory Problem
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Low thyroid
☐ High thyroid
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy

OTHER:
_____
_____
_____

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

Are you under the **care of a physician**? ☐ Yes ☐ No
If yes, please explain: _____

Name of Physician(s): _____ *Phone:* _____

Have you been advised to have or had any **operations or surgeries**? ☐ Yes ☐ No
If yes, please list: _____

Have you been **admitted to a hospital or needed emergency care** during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

Have you ever had any **adverse reaction or allergic reaction** to a serum, medicine, insect, drug, perfume, food, environmental allergen, nickel or metal? ☐ Yes ☐ No

If yes, please list: _____

Have you ever had recent or past difficulty with **bleeding**, after surgery or tooth extraction? ☐ Yes ☐ No

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

Date of Last Dental Visit: _____ Reason for this visit:_____

Do you **smoke**? ☐ Yes ☐ No Packs/day: _____

Do you **vape or use e-cigarettes**? ☐ Yes ☐ No Usage/day: _____

Do you use **marijuanna or other non-prescribed drugs**? *Please circle:* ☐ Yes ☐ No Usage/day: _____

Medications and Supplements:

Drug Name	*Strength*	*Oral/ Injection*	*X Per Day*

Reason for Visit

Reason for Dental Consult:

_____

_____

Referral Information

Who can we thank for **referring you** to our practice? *Please circle:*

☐ Another patient
☐ Friend
☐ Relative
☐ Dental office
☐ Internet
☐ Social Media
☐ Newspaper
☐ Work
☐ Other

Name of individual or practice who referred you: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify my dental provider of any changes at any subsequent visit.
I authorize Prosthodontics Limited, PC and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility.
I also consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature of Patient, Parent or Guardian: _____ Date:_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

I have been advised that Prosthodontics Limited, PC does not participate with any insurance company in order to provide the treatment that I need and want and not the treatment the insurance company dictates. Prosthodontics Limited, PC will fill out and submit all forms that I request. However, there will be no claims submitted for payment until I have satisfied the financial obligation that has been pre-arranged and with which I have agreed.

Signature of Patient, Parent or Guardian: _____ Date: _____

Authorization For Signature On File

Release of Information/Financial Responsibility/Authorization for Payment

I,_____and/or_____,
Name of Patient, Parent or Guardian Name of Insured

hereby authorize the Prosthodontics Limited, PC to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with _____. I hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed above.

I have reviewed the treatment plan and fees and I agree to be responsible for all charges for dental services and materials. To the extent permitted under applicable law, I authorize release of any information relating to the claim.

_____ _____

Signature of Insured **Date**

_____ _____

Signature of Patient, Parent or Guardian **Date**

Acknowledgement Of Receipt Of Notice Of Privacy Practice

You May Refuse to Sign This Acknowledgement

I, _____ have received a copy of this office's Notice of Privacy.
Name of Patient, Parent or Guardian

Signature: _____ **Date:** _____

For Office Use

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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify):

_____
_____
_____
_____
_____
_____
_____
_____

Philadelphia Department of Public Health (2009) Information Sheet

Amalgam Dental Fillings Containing Mercury

The Philadelphia Department of Public Health has developed this information sheet pursuant to Section 1 Title 9, Chapter 9-3100 of the Philadelphia Code. Its purpose is to give you information about amalgam fillings that contain mercury and other dental filling options. Your dentist's office should provide you with a copy of this sheet and answer any questions that you may have.

What is dental amalgam?

- Dental amalgam is the silver-colored material used to fill (restore) teeth that have cavities. It is one of several approved choices for filling cavities.
- Amalgam is made up of 50 percent mercury, a type of metal. Amalgam also contains other metals including silver, tin, copper and zinc.

Is dental amalgam that contains mercury safe:

- There is ongoing research and discussion about the health effects of mercury in amalgam fillings.
- Small amounts of mercury are released as a vapor (gas) when amalgam fillings are placed or removed and through chewing. This mercury can be absorbed by the body and may build up over time.
- High levels or mercury can cause toxic effects on the brain, nervous system and kidneys.
- Generally, people with amalgam fillings have higher levels of mercury in their blood, and urine than people without amalgam fillings. The mercury levels in people with amalgam fillings are not high enough to be considered toxic.
- So far, well-done studies have shown that amalgam fillings do not impact behavior, information processing and kidney function among children.
- It is more difficult to study the long-term effects of dental amalgam (effects that may appear later in life). Research in this area is still being performed.
- The Food and Drug Administration (FDA), which regulates the safety of medications and medical devices, has stated that "dental amalgams contain mercury, which may have neurotoxic effects on the nervous systems of developing children and fetuses." The FDA is currently reviewing data and will make a decision about how strongly to regulate the use of amalgam.

Are there alternatives to amalgam?

- Yes. Amalgam is one of several approved choices for filling cavities.
- The most common dental filling used today is resin composite, which does not contain mercury. Resin is usually tooth-colored.
- Other filling materials are a form of glass cement, porcelain, gold, and other metals.

Aside from safety issues, what are the pros and cons of amalgam and alternative filling materials?

- Amalgam fillings generally last longer than resin composite fillings, so they don't need to be replaced as often.
- Resin composite fillings are tooth-colored and, therefore, are preferred by some people for cosmetic reasons.
- There may be a cost difference between resin composite and dental amalgam.
- To protect the environment, amalgam must be disposed of as a hazardous waste.

What should you do?

- Talk to your dentist, ask questions, and make an informed choice about dental fillings if you have a cavity.

- Prevent cavities through regular brushing, flossing and dental exams.
- For more information on amalgam fillings that contain mercury:

The U.S Food and Drug Administration Questions and Answers on Dental Amalgam:
www.fda.gov/cdrh/consumer/amalgams.html
1-800-638-2041 (option 2) between 8:00 a.m. and 4:30 p.m.

Centers for Disease Control Dental Amalgam Use and Benefits Fact Sheet:
http://www.cdc.gov/oralHealth/publocatopms/factsjeets/a,a;ga,.htm

A copy of this information sheet has been provided to the patient (or patient's representative) and his/her questions, if any, have been answered.

Signature: _____ **Date:** _____

Consent For Use and Disclosure Of Health Information

Section A: Patient Giving Consent

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

Social Security # _____

Section B: To the Patient – Please read the following statements carefully

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contracting:

Contact Person: Dr.Leela Breitman **Telephone** (215) 728-1696 **e-mail**: Prosthodonticslimited@gmail.com

Address: 8021-B Castor Ave., Philadelphia, PA 19152

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature

I, _____have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I also consent to communication with my representative in all matters related to my treatment in this office.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____