Keystone Dental Care
a service of Keystone Health

Welcome to Keystone Dental Care!

We are honored you have chosen us to provide your dental treatment. We pride ourselves in offering comprehensive dental care. Please have the items listed below prepared to bring with you for your first dental visit.

- **Medical history -** including lists of surgeries, medications and supplements (complete Medical History form provided in packet)
- **Dental x-rays –** Please contact your previous dental care provider and bring any recent x-rays with you including your last full mouth series and/or panorex x-ray. Please note that a full mouth series and/or panorex is typically taken every 5 years. To have your records transferred to our office, see attached form.

A forms checklist is included in your packet to explain each form that needs to be completed and presented upon arriving for your appointment.

Your first appointment will consist of information gathering to establish you as our patient and to diagnose your dental needs. Each patient's needs and appointment is unique. The circumstances surrounding this first encounter with us may factor into whether all preventative services will be completed in one visit, or if additional visits are required.

Your first appointment may require more than one visit depending on the following:

- The condition of your teeth and gums
- Your need for x-rays
- Other existing Medical Condition

An initial appointment normally takes longer than future exams as it includes a comprehensive health history, dental x-rays, periodontal evaluation, and charting existing dental work. We will also be working with you towards developing a treatment plan that best suits your dental needs and goals.

We look forward to meeting you!

To be better prepared for your appointment, please refer to the following checklist to assist you with what you should bring with you and in completing the needed forms

Photo id

- **Current dental insurance card**- Needed at every visit
- **Medical insurance card**- Needed at every visit
- **Patient Registration –** Complete all information
- **Medical and dental history completed**
  Please make sure that you bring a complete list of surgeries, medications, and supplements along with the names and phone numbers of your medical doctors
- **Persons permitted in Treatment room with Patient**
  This form is to make you aware of our policy on persons allowed in the treatment room and those that can or cannot be left in the reception room unattended. You must read and sign it.
- **Permission to share PHI**
  This is giving us permission to share your protected health information with people that you designate.
- **Learning Assessment**
  This form will help us understand the best way to communicate with you based on your needs.
- **UDS Form**
  This form is a survey that collects information to help us better serve the community.
- **Authorizations for Record Transfer(if needed)**
  If you have been seen by another dentist, you can use this form to request the release of records. Some offices require that you use a form from their office. Contact your previous dentist for more information.

PATIENT REGISTRATION

Patient Information

Name: _____
First *Middle* *Last*

Address: _____

Social Security Number: _____Home phone: (____)_____ Cell Phone: (____)_____

Date of Birth: _____ Marital Status: _____ Gender: ◯ M ◯ F

Race: ◯ American Indian/Alaska Native ◯ Asian ◯ Black ◯ White ◯ Native Hawaiian ◯ Other Pacific Islander

Ethnicity: ◯ Hispanic or Latino ◯ Not Hispanic or Latino

Do you have medical insurance? ◯ Yes ◯ No

If you do not have insurance, would you like to get information about our reduced fee program? ◯ Yes ◯ No

Are you a US veteran? ◯ Yes ◯ No Are you homeless? ◯ Yes ◯ No

Parent's Information (Complete this section for a patient less than 18 years old)

Mother's Name: _____ Date of Birth:_____/_____/_____
First *Middle* *Last*

Father's Name: _____ Date of Birth:_____/_____/_____
First *Middle* *Last*

Is there a Legal Child Custody Agreement? ◯ Yes ◯ No

(If yes, are there any legal restrictions that would prevent the non-custodial parent from consenting to medical/dental treatment for the child or from obtaining information about the child's medical/dental treatment?) ◯ Yes ◯ No

*****Please provide proof of parental custody orders or other legal agreements*****

Emergency Contact Person

Name:_____/_____
First *Middle* *Last* *Relationship to patient*

_____/_____
Address *Phone*

Person Responsible for Payment (Complete this section for a patient less than 18 years old)

Name:_____/_____
First *Middle* *Last* *Relationship to patient*

Social Security Number: _____ Date of Birth: _____

Address: _____

Home phone: _____ Cell phone: _____

I agree that the above information is correct and accurate to the best of my knowledge. I also understand that any charge(s) not covered by my insurance(s) will be my responsibility.

Signature: _____ Date: _____

For Office Use Chart #: Insurance scanned: yes/no Date: Initials:

1/2/19 ksw

Patient Name _____ Date of Birth _____ Chart # _____
Last First Middle

Medical Physician _____ Last Medical Exam _____ Medical Physician Phone Number ( )_____

Do you have or have you had any of the following? (Check all that apply)

_____ ADHD/ADD
_____ Angina (chest pains)
_____ Arthritis
_____ Asthma
_____ Autism
_____ Cancer (type)_____
_____ Cardiac Pacemaker
_____ COPD
_____ Diabetes (type) _____
_____ Drug/Alcohol Problem
_____ Fainting/Seizure disorder
_____ GERD/acid reflux
_____ Glaucoma
_____ Hay Fever/Allergies
_____ Heart Attack, when?_____
_____ Heart Disease _____
_____ Heart Murmur
_____ Hepatitis (type)_____
_____ High Blood Pressure
_____ HIV/AIDS
_____ Joint Replacement
_____ Kidney Disease
_____ Liver Disease
_____ Low Blood Pressure
_____ Marijuana Use
_____ Mitral Valve Prolapse
_____ Recent Weight Loss
_____ Rheumatic Fever
_____ Sexually Transmitted Disease
_____ Thyroid Disease (type)_____
_____ Tuberculosis

Allergies & Reactions (Check all that apply)

_____ Local Anesthetic (Novocaine)
_____ Antibiotics
If so what? _____
_____ Sulfa Drugs
_____ Prescription Pain Medications
_____ Tylenol, Aspirin or Ibuprofen
_____ Metals (nickel, mercury, etc.)
_____ Latex Rubber
List Others: _____
_____
_____
____ No Known Allergies (check here)

Current Medications: (please list)

Medication name	Dosage	# per day	Reason

_____ Check Here if NO Medications

Health related substances

(Vitamins, herbal or natural products)

Medication	Dosage	# per day

Additional Health History

1. Have you ever taken Fosamax, Zometa, Aredia, Boniva or any medications for Osteoporosis (bone loss)? Yes No
2. Are you under medical treatment now? If yes, please list_____ Yes No
   _____
3. Have you ever had a serious illness/major surgery? If yes, please list_____ Yes No
   _____
4. Do you use tobacco?(circle) smoke chew snuff electronic/vap Yes No
5. Have you been diagnosed with an eating disorder? Yes No
6. Have you been diagnosed with any psychiatric, bipolar, ODD or anxiety disorders? Yes No
   If yes, please explain _____
7. Have you been diagnosed with depression or PTSD? Yes No
8. Have you been diagnosed with a physical disability? If yes, please explain_____ Yes No
   _____
9. Women Only:
   Are you pregnant or think you may be? Yes No
   Are you nursing? Yes No
   Are you taking oral contraceptives? Yes No

Office Use Only:

I Certify that the above information is complete and accurate.

Patient/Guardian Signature _____Date:_____ Provider Signature _____

Patient Name _____ Date of Birth _____ Chart # _____

DENTAL HISTORY

Name of Previous Dentist and Location _____Date of last Exam _____

1. Purpose of initial visit_____
2. Are you aware of a problem?_____
3. How long since your last dental visit?_____
4. What was done at that time?_____
5. When were your teeth last cleaned?_____
6. Have you made regular visits? Yes No
7. Were Dental X-rays taken? Yes No
8. Do you have missing teeth? Yes No
9. How have they been replaced?_____
10. Are you happy with the replacement? Yes No
11. Have you had any problems with previous dental treatment?_____
12. Do you clench or grind you teeth? Yes No
13. Does your jaw click or pop? Yes No
14. Do you have pain or soreness in the muscles of your face or around your ear? Yes No
15. Do you have frequent headaches, neck aches or shoulder aches? Yes No
16. Does food get caught in your teeth? Yes No
17. Are any of your teeth sensitive to: Circle below
    Hot Cold Sweets Pressure
18. Do your gums bleed or hurt? Yes No
19. Do you experience dry mouth? Yes No
20. How often do you brush your teeth & when?_____
21. Do you use dental floss? Yes No
22. Are any of your teeth loose, tipped, shifted? or chipped? Yes No
23. Are you unhappy with the appearance of your teeth? Yes No
24. How do you feel about your teeth?_____
25. Do you feel your breath is offensive at times? Yes No
26. Have you ever had gum treatment or surgery? Yes No
27. Have you had any orthodontic work? Yes No
28. Have you had any unpleasant dental experiences or is there anything about dentistry you strongly dislike?

_____

29. Do you have any questions or concerns? Yes No

_____

Office Use only:

Patient/Guardian Signature _____ Date: _____

Dentist Signature _____ Date: _____

****NOTICE TO ALL PATIENTS and PARENTS****

Keystone Dental Care now requires that only one (1) person be allowed in the treatment area with the patient being seen for the appointment. We give utmost importance to the safety and security of our patients and their families. Allowing more than one (1) person in the treatment area affects those safety measures.

Parents & Patients

1. When a child is being seen, other children will not be allowed in the treatment area. Children under the age of 13 or special needs persons are not to be left in the waiting room without a parent or guardian present.

2. Adults - If you are the patient with the appointment, we can not allow unattended young children or special needs persons in the treatment area who may require supervision.

Our employees are not able to baby-sit or take care of your children while you are receiving treatment. When scheduling your appointment please keep in mind that you will need to arrange child care or bring another adult to attend your child in the waiting area.

3. A Parent or legal guardian must be present at the first visit or any consent required visits, such as Root Canal or Extraction. A Keystone Parental Permission form must be signed and dated for any other adult to bring your children to basic services visits (exam, cleanings, fluoride, x-rays, fillings and sealants).

4. All minor children under the age of 18 must have a parent, guardian or approved adult in the office during the entire treatment time. If the adult leaves the office the treatment will be rescheduled.

5. Failure to comply with these policies may result in our not being able to see you for your appointment.

Patient Name (Please Print) _____ Date:_____
Patient/Parent/Guardian Signature: _____ Date: _____

PERMISSION TO SHARE PROTECTED
HEALTH INFORMATION

Patient's Full Name: _____
(First) (Middle) (Last)

Patient's Date of Birth: _____/_____/_____Telephone:_____

Keystone Health shares one electronic record. Any person(s) you authorize will have access to your financial/medical/dental and behavioral health information.

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Keystone Health uses a reminder system and/or patient portal to communicate with our patients. Please complete the information below, so that we may keep in touch with you regarding your health.

Cell Phone:_____(you will receive a text message)

E-mail:_____ (you will receive an email)

By signing, I give permission to Keystone Health to share my protected health information to the individuals listed. This permission remains in effect until revoked in writing.

_____ _____

Signature of Patient or Authorized Representative Date

(Patients 14 years and older must sign if consenting for treatment on own behalf)

_____

Staff Initials

PATIENT LEARNING ASSESSMENT

As part of Keystone Health, we strive to meet the diverse needs of our patients. Please complete the following questionnaire to assist us in making every attempt to meet your learning needs. Please let us know if you need help in completing this form. Thank you.

1. Are you able to read? □ Yes □ No
2. Are you able to write? □Yes □No
3. Do you want to learn about your health needs? □ Yes □ No
4. Please indicate level of education (last grade of school completed) _____
5. Please indicate your dominant language. □English □ Spanish
   □Other_____
6. Do you need a translator? □ Yes □No
7. Do you use a hearing aid? □ Yes □ No
8. Do you use other device(s) to aid in communication? □ Yes □ No
   If yes, please explain_____
   _____
9. Please indicate any possible barriers to education: □ None □ Cultural
   □Emotional □ Religious □Physical Limitations □ Visual/Hearing Limitations
   □ Limited Learning Ability □ Learning Deficit
   If any barriers checked, please specify_____
   _____
10. Please check preferred learning style(s). Please check all that apply.
    □ Reading a handout or pamphlet
    □Watching a demonstration then doing task
    □ Listening to someone provide explanation on the topic
    □ Watching the topic on tape

Patient's Name _____ Date of Birth _____

Patient's Signature _____

If patient is unable to sign, name of person completing form_____

Relationship to patient_____

Staff Initials_____ Date _____

PATIENT LEARNING ASSESSMENT

As a Community Health Center, our mission is to take care of people no matter what their race, ethnicity or income. This survey will help us know if we are helping all kinds of families within our community. Please fill in the information below to best tell us about you and your family.

Race- relates to a persons appearance such as skin color:

□ **White/Caucasian** □ **Black/African American** □ **Asian** □ **American Indian**
□ **Native Hawaiian** □ **Other Pacific Islander**

Ethnicity- relates to nationality and culture:

□ **Latino/Hispanic** □ **Non Latino**

Family Size	**Annual Family Income**			
1	☐ up to $12,760	☐$12,761 to $19,140	☐$19,141 to $25,520	☐$25,521 and above
2	☐ up to $17,240	☐$17,241 to $25,860	☐$25,861 to $34,480	☐$34,481 and above
3	☐ up to $21,720	☐$21,721 to $32,580	☐$32,581 to $43,440	☐$43,441 and above
4	☐ up to $26,200	☐$26,201 to $39,300	☐$39,301 to $52,400	☐$52,401 and above
5	☐ up to $30,680	☐$30,681 to $46,020	☐$46,021 to $61,360	☐$61,361 and above
6	☐ up to $35,160	☐$35,161 to $52,740	☐$52,741 to $70,320	☐$70,321 and above
7	☐ up to $39,640	☐$39,641 to $59,460	☐$59,461 to $79,280	☐$79,281 and above
8	☐ up to $44,120	☐$44,121 to $66,180	☐$66,181 to $88,240	☐$88,241 and above
9	☐ up to $48,600	☐$48,601 to $72,900	☐$72,901 to $97,200	☐$97,201 and above
10	☐ up to $53,080	☐$53,081 to $79,620	☐$79,621 to $106,160	☐$106,161 and above

Revised 2.18.20

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Please read and complete all items

Patient Name: _____ Date of Birth_____
(First) (Middle) (Last)

Address: _____
(Street) (City/State) (Zip)

Home Phone: _____ Cell Phone: _____

I authorize: ☐ **KEYSTONE HEALTH (network) or: (Select a location)**

☐ Keystone Family Medicine ☐ Keystone Internal Medicine ☐ Keystone Pediatrics ☐ Keystone Women's Care
☐ Keystone Behavioral Health ☐ Keystone Urgent Care ☐ Keystone Dental ☐ Keystone Chiropractic
☐ Keystone Foot and Ankle ☐ Keystone Pediatric Developmental Center (OT/Audiology& Speech)
☐ Keystone Community Health Services (Infectious Disease & Community Outreach Programs)

to:

☐ **obtain from**: _____
(Organization)
Address_____
_____
_____
(Phone) (Fax)

☐ **disclose to**: Keystone Dental Care
(Organization)
Address 767 Fifth Ave., Suite B-3a
Chambersburg, PA 17201
717-263-8014
(Phone) (Fax)

the following information from my medical record (*please specify date range*)

Dates of service (from) _____ (to) _____

☐ **Complete Medical Record** (Physician office notes, outpatient consult reports, diagnostic reports, laboratory results and hospital reports from all locations listed above, for the period of the last 3 years, unless specified above)

☐ **Complete Dental Record** (Dentist office notes, consult reports and x-ray images for the period of the last 3 years, unless specified above)

Or: Select items-

☐ Diagnostic Test Results (please specify) _____
☐ Itemized Billing Statement ☐ Physician Office Notes ☐ Immunization Record
☐ Outpatient Consult Notes ☐ Hospitalization Reports ☐ Mental Health Records
☐ Other (please specify): _____

For the purpose of:

☐ Transfer of Care ☐ Continuity of Care ☐ Insurance Reasons ☐ Verbal Exchange ☐ Treatment
☐ Relocation/Moved ☐ Legal Investigation ☐ School Exchange ☐ Unhappy with Care
☐ Other_____

How information is to be provided:

☐ Paper Copy ☐ Electronic Copy (Thumb Drive/CD)

Method of Delivery

☐ US Mail ☐ Fax ☐ Pick up in Office

- I understand that fees may be charged for paper copies in accordance with the limitation on fees charged to patients and their personal representatives under HIPAA and the limitations on fees for others under PA Law. {55 Pa Code §5100.34}. A flat fee of $6.50 per electronic format request as permitted by HITECH ACT.
- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral health services and treatment of alcohol or drug abuse. **State and Federal Law protect the following information.**

I authorize the release of the following information:

Drug and Alcohol Treatment	☐ Yes ☐ No	Dates: _____
Behavioral Health Treatment	☐ Yes ☐ No	Dates: _____
HIV/AIDS	☐ Yes ☐ No	Dates: _____
Sexual Abuse/Assault Counseling Treatment	☐ Yes ☐ No	Dates:_____
Reproductive Health/STD Treatment	☐ Yes ☐ No	Dates: _____

- I understand that this authorization is voluntary and I may refuse to sign and my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.
- I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under the terms of this authorization.
- I understand that I may revoke this authorization in writing at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Keystone Health Center. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand this authorization will expire: one (1) year from the date of this form unless otherwise specified or earlier terminated in writing by patient. Specify Date (less than one year) ____/_____/_____.
- I understand this authorization will not be accepted unless it is completed in its entirety. A copy of this form will be accepted in lieu of an original.
- I understand that if I am a minor, under the age of 18, and have consented to health services involving, *reproductive health /STD testing, drug and alcohol or behavioral health treatment,* that my signature is required for any disclose of such Information.

My signature acknowledges that my representative or I have been offered and/or received a copy of this document that I have read and understand the content of this authorization, and voluntarily consent to the release of information.

_____ _____
Signature of Patient or Personal Representative Date

_____
Personal Representative/ Relationship

If patient is unable to consent or is a minor, complete the following:
If signed by a person other than the patient, select the relationship. ***Legal documentation may be required.***

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority: ☐ Legal Guardian ☐ Custodial Parent ☐ POA ☐ Personal Representative
☐ Executor of Estate

VERBAL AUTHORIZATION: This portion to be completed when a patient is unable to give written consent.
We, the undersigned, do verify that the above authorization has been read to the client and that they have indicated they understand the nature of the authorization and freely give their verbal consent for the release of the above information.

_____ _____
Signature of Responsible Person (witness) Date

_____ _____
Signature of Responsible Person (witness) Date

PLEASE MAIL OR FAX THIS FORM AND RECORDS TO:

Keystone Dental Care
767 Fifth Ave., Suite B-3a
Chambersburg, PA 17201
Phone Number: (717)709-7940
Fax Number: (717) 263-8014
keystonedental@keystonehealth.org

**********--DISPOSITION OF RELEASE ------ OFFICE USE ONLY --**********

Faxed: _____ Mailed: _____ Patient pick-up:_____ Staff Initials _____ Date_____