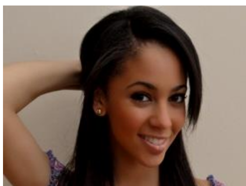
Office of Debra V. Irvin, DDS, PC



Welcome

Name____

Home #_______________________ **Cell #**________________

Address____

City_________________ **State**_____ **Zip**_________

Date of Birth ___/_____/______ **Soc. Sec.#** ________________

Email Address____

Driver's License #______________________________

Payment Type: Self-pay (Cash, Credit Card)______ **Insurance** _______

Employer_______________**Work Phone #**_____________

If Patient is a Student, name of School/College______________________

Whom May We Thank for Referring You__________________________

Emergency Contact_____________**Relationship** ________ **Phone #**________

MEDICAL HISTORY

*1. Physician*____________________________________ *Date of Last Physical*___________________

Physician ***Phone #***____________________________

Pharmacy Name __________________________ **Pharmacy Phone #**_______________________

2. Please list all hospitalizations, diagnosis(es) and dates:

3. Please list all medication(s) including prescription, herbal and non-prescription:

Have you ever taken bisphosphonates for cancer or osteoporosis treatment?

Are you taking blood thinners?

4. Do you use tobacco products?…………… Do you use medical marijuana?................................

5. Do you use alcohol?……………. Do you use weed or other street narcotics?…………………….

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6. Are you wearing contact lenses?………………………….

7. Are you taking hormone therapy? Please name the hormone _________________________________

Are you allergic or have you had a reaction to any of the following?

	YES	NO	
• *Penicillin or other* Antibiotic……………*	☐	☐	***OTHER*** ....
• **Sul***fa* ……..……………………………….	☐	☐	
• *G6PD Deficiency*………………………….	☐	☐	
• *Codeine*..…………………………….….	☐	☐	
• *Latex*..………………………………….…...	☐	☐	
• *Aspirin*………………………………….…	☐	☐	
• *Lidocaine (Xylocaine)*……………………...	☐	☐	
• *Epinephrine (Adrenaline)*…………………	☐	☐	
• *Other Medications*…………………………	☐	☐	*If yes, please name:* ________________________ _

8. ***Women only: Are you nursing?…………… Are*** **you** ***pregnant?………… # of weeks………………..***

Are you using hormonal birth control: pills, injection, patch, vaginal ring or implant rods?....................

9. Has a medical professional ever told you that you have any of the following:

Yes No

- ***High Blood Pressure***……………………..……......☐ ☐
- ***Cancer***…………………………………………....☐ ☐ **WHERE ....**
- ***Heart Attack***………………………………..…...☐ ☐ **WHEN...**
- **Joint Replacement/Implant:**
  Knee, hip, shoulder…………..................☐ ☐
- **He*patitis/Liver Disease***………………………......☐ ☐ **TYPE..**
- **Epilepsy/*Seizures***………………………………......☐ ☐
- ***Sexually Transmitted Disease***……………….........☐ ☐
- ***Asthma or COPD***…………………….............. .☐ ☐
- ***Stomach Troubles/Ulcers/Acid Reflux***…….…....☐ ☐
- **Blood Disorder/*Clotting Problems***………..........☐ ☐
- **Organ Transplant**………………………….........☐ ☐
- ***Sleep Apnea***………………...........................☐ ☐
- ***Chest Pains***………………………………..…......☐ ☐
- ***Diabetes***…………………………………..............☐ ☐ **A1C LEVEL ……………………..**
- ***Stroke***……………………………………….........☐ ☐ **WHEN...**
- ***Kidney Disease/Dialysis***……………………….........☐ ☐
- ***AIDS or HIV*** ……….....…………………..............…..☐ ☐
- ***Corona Virus***…………………………………… ☐ ☐
- ***Tuberculosis Disease***…………………………… ☐ ☐
- ***Thyroid Condition.***…………………….................☐ ☐ **TYPE………………………………..**
- ***Sickle Cell Disease***………………………....…..☐ ☐
- ***Mitral Valve Prolapse***……………….................☐ ☐
- ***Recent Weight Loss***………………………...….☐ ☐
- ***Cardiac Pacemaker or Stent***…………………….☐ ☐
- ***Angina***……………………………,,,,,,,,,,,,….....☐ ☐
- ***Congenital Heart Defects (at birth)***…………… ☐ ☐ **TYPE………………………………..**
- ***Irregular Heartbeat (slow or fast)***……………..☐ ☐
- ***Anemia***…………………………..….............…..☐ ☐
- ***Lupus***...☐ ☐
- ***Emphysema***…………………..........………......☐ ☐
- **Mental Health Condition**……………………......☐ ☐ **Diagnosis ______________________________**
- **Sjogren's Syndrome**…………………………☐ ☐
- ***Other***…………………………………….….. ***If other, please state:*** **_______________**
-

10. Has a medical doctor ever told you to take antibiotics before dental treatment because of a medical condition? Please name the condition____

11. Have you ever taken chemotherapy or radiation treatment? When……………………………..
Area of the body …………………………

***DENTAL HISTORY*:**

	Yes	*No*
1. Do your gums bleed while brushing or flossing?…...	☐	☐
2. Are your teeth sensitive to hot or cold	☐	☐
3. Are your teeth sensitive to sweet or sour...................	☐	☐
4. Do you feel pain in your mouth?…...........................	☐	☐

5. Do you have any mouth sores or swelling?...... .. ☐ ☐
6. Have you had any head, neck, or jaw injuries?…….☐ ☐
7. Have you ever experienced any of the following :
a) Clicking of the jaw joint?……....................…...☐ ☐
b) Pain (joint, ear, side of face)?....……................☐ ☐
c) Difficulty in opening or closing?….....................☐ ☐
d) Difficulty in chewing?………….......................☐ ☐
8. Do you have frequent headaches?……………………☐ ☐
9. Do you clench or grind your teeth?……………........☐ ☐
10. Do you nibble or bite your lips, cheeks or tongue frequently?…………………………………...........☐ ☐
11. Have you ever worn braces?……….............……....☐ ☐
12. Have you ever had any prolonged bleeding following tooth removal? ……………………….…….☐ ☐
13. Do you snore?.. ☐ ☐
14. Do you suffer with a dry mouth?…………………. ☐ ☐
15. Do you have a dental phobia or dental fears? Please explain:

Authorization and Release

You agree that Debra V. Irvin, DDS, PC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, sending text messages or emails, using any email address that you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable. I certify that I have read and understand the above information to the best of my knowledge. The previous questions have been accurately answered. You understand that providing incorrect information can be dangerous to your health. You authorize Debra V. Irvin, DDS, PC to release any information including the diagnosis and the records of any treatment or examination rendered to you or your dependent during the period of such dental care to third party payers and/or health practitioners. You authorize the insurance company to pay directly to Debra V. Irvin, DDS, PC all insurance benefits otherwise payable to you. You understand that the dental insurance carrier may pay less than the actual bill for services. You agree to be responsible for payment of all services rendered to you and/or your dependents.

____ _______________
Signature of Patient/Guardian ***Date***

____ _______________
Dentist Signature **Date**

Financial Policy

Payment Options:

A. **Dental services can also be paid with MC, VISA, AE, Discover, and dental insurance. We do not accept checks.**
B. **With major treatment you may choose to pay 50% of your out-of-pocket portion on the start appt, 1/4 on the try-in appt, and the final 1/4 on the delivery appt..**

C. With major treatment you may prefer to secure a bank, credit union, or other third- party financing for the entire amount and make payments to the lending institution.

D. Monthly interest-free payment plans are available via Care Credit (carecredit.com).

Insurance: You must provide the complete insurance info for us to bill your insurance company. Although we may estimate what your insurance company should pay, it is the insurance company that makes the final determination of your benefits. If your insurance fails to pay your claim, you will be billed. You agree to pay any portion of your charges not covered by insurance. All copays must be paid at the appointment of service, prior to being seated for treatment.

Missed Appointment Fee: We request 3 business days' notice if you are unable to keep your appointment, this time period allows us the time to offer the appointment to another patient. A Missed Appointment charge of $50.00 per half hour will be placed on the account of patients who miss an extended appointment or patients who have a pattern of failing to give us notice when unable to keep the appointment. Patients with three (3) missed appointment charges on their account may be scheduled on a "Day Of" basis only or dismissed from the practice.

Extended Appointments: For all appointments 1 1/2 hours in length or greater, we may collect a Reservation Fee (1/3 of the money due for the procedure) at the time the appointment is scheduled. If you don't give us 3 business days' notice, the failed appointment charge will be deducted from this collected Reservation Fee.

Payments: Payments will be collected before you are seated in the treatment room. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable within 30 days of the statement date. Your account is past due if not paid within 30 days of the statement date.

Finance Charge: A finance charge will be imposed on your account which remains unpaid for sixty (60) days or more. The FINÄNCE CHARGE will be computed at the rate of 1.5% per month or an ANNUAL PERCENTAGE RATE of eighteen (18) percent.

Past Due Accounts: If your account becomes past due, we will take all necessary steps to collect this debt. We have the option to report your account to a credit reporting agency/bureau or refer your account to a lawyer. You agree that our collection fee is a legal and a lawful debt. You agree to pay the collection fee for the services of the collection agency. If we refer the account balance to a lawyer, you agree to pay all the lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Philadelphia County.

Divorce/Separation: The parent authorizing treatment for a child will be the parent responsible for the payment. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent, this is not our responsibility.

Minor Patients:
Non-Emergency Appointment: If the minor child is sent to the dental appointment without the payment and no prior written financial arrangements have been made with our office, the appointment will be cancelled.

Returned check: There is a return check charge (NSF) for any checks returned.

Transferring of Records: You will need to pay the Record Duplication Fee if you want to have your records faxed or mailed to another dentist or third party. This fee must be received by our office before your records will be transferred. We will not charge a Record Transfer Fee if your records are emailed

to another dentist or third party. If you are requesting your records to be transferred from another dentist to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation and Personal Injury: We require you to pay us for your services rendered, we will complete the paperwork necessary for your reimbursement. Payment of the treatment bill remains the patient's responsibility. We will not bill your attorney for your dental treatment nor negotiate the bill with your attorney.

Dental Appliances: Payment of ALL insurance claims must be received by our office before dental appliances will be inserted. If a patient desires to have the appliance inserted before the insurance claims are received, the patient must pay the entire account balance and we will refund the credit balance upon receipt of the insurance payment.

Temporary Restorations: Rarely do temporary crowns come off, but if this does happen the office must be notified immediately so that we can advise the patient of what to do. If the temporary remains off the tooth for an extended period, the tooth could shift position. The movement of the tooth could require a new impression, a remake of the appliance and an additional cost that the patient will occur. Your dental insurance will not pay for this remake of the appliance.

Proof of Identity: Adult patients and guardians of minors or incapacitated adult patients must provide photo ID.

I have been informed of the office financial policy,

____ __________

Signature of Patient/Guardian Date

ATTENTION: PRIVACY CONSENT FORM

By signing below, you consent to the use and disclosure of your protected health information by DEBRA V. IRVIN, DDS, PC, our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Privacy Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting DEBRA V. IRVIN, DDS, PC at (215) 329-5512 and requesting a revised Notice. We have also posted a notice in the office of DEBRA V. IRVIN, DDS, PC.

You have the right to request that we restrict our uses or disclosures of your protected health, information that we are otherwise permitted to make for treatment, payment and health care operations,

although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

I HAVE REVIEWED & UNDERSTAND AND AGREE TO THIS NOTICE OF PRIVACY.

____ ____________________

SIGNATURE OF PATIENT/GUARDIAN **DATE**

ATTENTION: FOR PATIENTS WTH DENTAL INSURANCE

AUTHORIZATION FOR SIGNATURE ON FILE

I,____

PRINT NAME OF PATIENT/GUARDIAN

hereby authorize the office of Debra V. Irvin, DDS, PC to affix my name to all claims or documents related to all health benefits due me and my dependents.

I authorize the release of any information relating to my health care claims. I understand that I am responsible for all costs of dental treatment. I hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed above.

____

SIGNATURE OF PATIENT/GUARDIAN

Initial Patient Sleep Screening Form - Debra V. Irvin, DDS, PC

Name ______________________ Date ______________

Section 1: Epworth Sleepiness Scale:

Please indicate how likely you are to doze off or fall asleep in the following situations:

0=would NEVER doze
1=SLIGHT chance of dozing
2=MODERATE chance of dozing
3=HIGH chance of dozing

Sitting and reading ______________
Watching TV ______________
Sitting inactive in a public place ______________
As a passenger in a car for an hour without a break ______________
Lying down to rest in the afternoon ______________
Sitting and talking to someone ______________
Sitting quietly after lunch without alcohol ______________
In a car, while stopped for a few minutes in traffic ______________

TOTAL SCORE ______________

Section 2: Subjective Sleep Evaluation:

Please circle yes or no for each question

Do you snore? ______________ Y/N
Would you or your spouse consider your snoring louder than a person talking? ______________ Y/N
Your snoring occurs almost every night ______________ Y/N
Is your snoring bothersome to your bed partner? ______________ Y/N
Do you feel that your sleep is not refreshing or restful? ______________ Y/N
Do you wake up with headaches? ______________ Y/N
Are you tired during the day & have a hard time staying awake? ______________ Y/N
Do you have trouble remembering things or paying attention during the day? ______________ Y/N
Do you have high blood pressure? ______________ Y/N

TOTAL Y SCORE ______________

Section 3: Prior Diagnosis:

Have you previously been diagnosed with Sleep Apnea? If yes, when were you diagnosed?

Was CPAP recommended for treatment? Do you still use your CPAP every night?