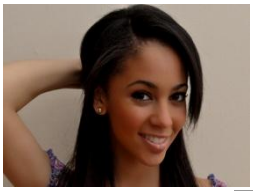
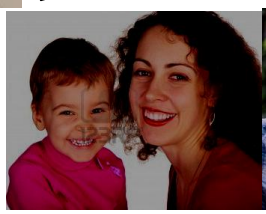
Office of Debra V. Irvin, DDS, PC



Welcome



Name_____

Home #_____ **Cell #**_____

Address_____

City_____ **State**_____ **Zip**_____

Date of Birth __/_____/_____ **Soc. Sec.#** _____

Driver's License #_____

Email Address_____

Check Appropriate Payment Box: _____Cash ___Check ___Credit Card _____Insurance

Employer_____

Work Phone #_____ **Work Address**_____

City_____ **State**_____ **Zip**_____

If Patient is a Student, name of School/College_____

Whom May We Thank for Referring You To Us_____

Name & Phone # To Contact in Case of an Emergency_____

_____

Office of Debra V. Irvin, DDS, PC - MEDICAL HISTORY

***Physician*_____ *Phone* Number_____**

***Date of Last Physical*_____ Fax Number _____**

Pharmacy Name _____ Phone Number _____

***1. Are you under medical care now?……..* Please list the diagnosis:**

_____.

2. Please list all hospitalizations, diagnosis and dates:

_____.

.

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

_____

_____.

Have you ever taken biophosphonates for cancer or osteoporosis?

Are you taking blood thinners?

4. Do you use tobacco products?……

5. Do you use alcohol?……. Street narcotics?…….. .

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

7. Are you allergic to or have you had any reactions to the following:

	YES	*NO*
• *Local Anesthetics (e.g.novacaine)……..…*	☐	☐
• *Penicillin or other Antibiotics……*	☐	☐
• Sul*fa Drugs……..*	☐	☐
• *Barbiturates……..*	☐	☐
• *Sedatives……..…*	☐	☐
• *Iodine……..…...*	☐	☐
• *Aspirin……..…*	☐	☐
• *Other……..…..*	☐	☐

OTHER .....

If yes, please state: _____

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?.....

Office of Debra V. Irvin, DDS, PC – MEDICAL HISTORY

9. Do you have or have you had any of the following:

	Yes	No	
• ***High Blood Pressure***	☐	☐	
• ***Cancer***	☐	☐	**WHERE .....**
• ***Heart Attack***	☐	☐	**WHEN.....**
• **Joint Replacement/Implant: Knee, hip, shoulder**	☐	☐	
• **Hepatitis/*Liver Disease***	☐	☐	**TYPE.....**
• **Epilepsy/*Seizures***	☐	☐	
• ***Sexually Transmitted Disease/Infection***	☐	☐	
• ***Asthma or COPD***	☐	☐	
• ***Stomach Troubles/Ulcers/Acid Reflux***	☐	☐	
• **Blood Disorder/*Clotting Problems***	☐	☐	
• **Organ Transplant**	☐	☐	
• ***Sleep Apnea***	☐	☐	
• ***Chest Pains***	☐	☐	
• ***Diabetes***	☐	☐	
• ***Stroke***	☐	☐	**WHEN.....**
• ***Kidney Disease/Dialysis***	☐	☐	
• ***AIDS or HIV Infection***	☐	☐	
• ***Tuberculosis***	☐	☐	
• ***Thyroid Condition***	☐	☐	
• ***Radiation Therapy***	☐	☐	
• ***Mitral Valve Prolapse***	☐	☐	
• ***Recent Weight Loss***	☐	☐	
• ***Cardiac Pacemaker***	☐	☐	
• ***Angina***	☐	☐	
• ***Heart Condition***	☐	☐	
• ***Anemia***	☐	☐	
• ***Lupus***	☐	☐	
• ***Emphysema***	☐	☐	
Other			***If other, please state:*** _____

- **Has a medical doctor ever told you to take antibiotics before dental treatment? Why?**

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 any of your teeth?	☐	☐

Office of Debra V. Irvin, DDS, PC - DENTAL HISTORY

5. Do you have any sores in/or near your mouth?..... ☐ .☐
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 teeth removal? ……..….☐ ☐
13. Have you ever had instructions on the correct method of brushing and flossing your teeth? …..☐ ☐
14. Do you wear dentures?
15. Do wake up frequently during the middle of the night? ☐ ☐
16. Do you snore? ☐ ☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Debra V. Irvin, DDS, PC to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Debra V. Irvin, DDS, PC insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on the behalf of my dependents.

_____ _____

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

_____ _____

Dentist Signature **Date**

Debra V. Irvin, DDS, PC Financial Policy

Payment Options:

A. **Payment by cash, check, MC, VISA, AE, Discover, and dental insurance.**
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. **We offer monthly payments through Care Credit. There will not be any interest charged if you pay your Care Credit account in full by the due date.**

Insurance: You must provide the complete insurance info for us to bill your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. 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 our charges not covered by insurance. All copays must be paid at the appointment of service.

Missed Appointment Fee: We request 3 business days notice if you are unable to keep your appointment. A Missed Appointment charge of $50.00 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 taken out of 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. The minimum Finance Charge is $.50.

Past Due Accounts: 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.

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 lawful debt and you agree to pay the collection fee of 33.33% for the services of the collection agency. If we have to refer the collection of 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.

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

Financial Policy – Final Page

Transferring of Records: You will need to pay the Record Duplication Fee if you want to have copies of your records sent to another dentist. This fee must be received by our office before we will duplicate your records. 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. We will not charge a Record Duplication Fee if your records are emailed to another dentist or organization.

Workers Compensation and Personal Injury: We require you to pay us for your services, we will complete the paperwork necessary for your reimbursement. Payment of the bill remains the patient's responsibility. We will not bill your attorney for your dental treatment.

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 paid, the patient must pay the account balance in full.

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.

Proof of Identity: Adult patients and guardians of minor/incapacitated adult patients must provide photo ID when paying with credit cards or insurance.

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 DEBR.A 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,_____
hereby authorize the office of Debra V. Irvin, DDS, PC to affix my name to any and all claims or documents related to any and 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

Philadelphia Department of Public Health (2009) Information Sheet - Amalgam Mercury Dental Fillings

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 materials
Your dentist's office should provide you with a copy of this sheet and answer any questions that you may have.

1. What is dental amalgam?

• Dental amalgam is the silver-colored material used to fill teeth that have cavities. lt 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. -

2. 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 of 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.
• lt 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 amalgam contains 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.

3 . 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, resin is usually tooth-colored.
Other filling materials are a form of grass cement, porcelain, gold, and other metals.

4. Aside from safety issues, what are the pros and cons of amalgarn and alternatives?

• Amalgam generally last longer than resin composite fillings, so they don't need to be replaced as often.
• Resin composite fillings are tooth-colored and, 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.

5. What should you do? Talk to your dentist, and make an informed choice about dental fillings if you have a cavity. For more Information on amalgam fillings that contain mercury: www.fda.gov/cdrh/consumer/amalgams.html and Centers for Disease Control Dental Amalgam Use and Benefits Fact Sheet: http: //www .cdc.gov/oral Health/publications/factsheets/amalgam.htm or call toll-free 1-800-638-2041 (öpti6n #2) between 8:00 a.m. and 4:30 p.m

Patient Signature _____ Date _____

Dentist Signature _____ Date _____

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?