SAUCON VALLEY DENTAL

# Patient Registration Form

Date: _____
Patient Name: _____ Birthdate: _____ Sex: M F
Address: _____
Email Address: _____ Home Phone: _____
SSN:_____-_____-_____ Marital Status: **S M D W** Cell Phone: _____

## Person Responsible For Account

Name: _____ Relationship to Patient: _____
Address: _____ Phone: _____
Employer: _____ ID/SSN: _____
Insurance Company: _____ Group No: _____

## Dental History

Previous Dentist: _____ Reason for leaving: _____

Have you had any of the following?

| | | |
|---|---|---|
| Loose Teeth | Yes | No |
| Gum Pain/swelling | Yes | No |
| Bleeding when brushing | Yes | No |
| Gum/periodontal disease | Yes | No |
| Periodontal Surgery | Yes | No |
| Oral Surgery | Yes | No |
| Root Canal Treatment | Yes | No |
| Orthodontics | Yes | No |
| Click/noise in jaw | Yes | No |
| Pain in ear or jaw | Yes | No |
| Pain or difficulty chewing | Yes | No |
| Pain opening mouth | Yes | No |
| Treatment for TMJ | Yes | No |
| If child, suck thumb/finger? | Yes | No |

Injury to head or mouth? Yes No
Describe: _____
History of Headaches? Yes No
How frequently? _____

Sensitivity? Cold Hot Sweet
Do you have any of the following habits?

| | | |
|---|---|---|
| Grind or clench teeth? | Yes | No |
| Bite nails? | Yes | No |
| Hold objects in mouth? | Yes | No |
| Breathe through mouth? | Yes | No |
| Smoke or chew tobacco? | Yes | No |
| Drink coffee or tea? | Yes | No |

How often do you brush? _____ Type of toothbrush? _____ If child, does a parent help? _____
Do you floss? _____ If so, how frequently? _____ Fluoride taken in any form? _____
How do you feel about having dental treatment done? Have you ever had an uncomfortable experience? _____
Is there anything else we should be aware of? _____

Signature: _____

# MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

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 _____ DATE _____

# Office Policies and Financial Agreement

It is our desire to provide the highest quality of dental care to everyone. The following is a statement of Saucon Valley Dental PLLCs dental office's Policies and Financial Agreement. We ask that you please read, agree to, and sign before any treatment is rendered.

**Regarding Insurance**
Our goal is to maximize your insurance benefits. It is important to understand that the insurance contract is between the insurance company and you, the insured. Dental insurance was not designed to pay for all dental care. Treatment recommended by Saucon Valley Dental PLLC and his associates is never based on what your insurance company will pay. Due to pending claims and patient privacy issues, we do not always know how much an insurance company has already paid to another office or specialist, and the balance remaining on a yearly maximum. Please be prepared to show your insurance card and driver's license at the time of your visit. It is the patient's / guarantor's responsibility to provide any new information regarding insurance. Our office will gladly submit your insurance claim to your insurance carrier, as a courtesy to you. At the time of treatment, the patient / guarantor is responsible for the estimated portion the insurance does not cover. If for some unforeseen reason your insurance carrier has denied or not made payment within 60 days, the patient / guarantor is responsible for the balance in full. _____ **(Initial)**

**Payment Options**
Cash, Check, MasterCard, Visa, Care Credit

**3rd Party Financing**
With prior approval, we are pleased to offer a choice of No Interest or Extended Payment Plans to qualified applicants through Care Credit. If you would like to make extended payments for services provided at our office, please ask any of our administrative team for assistance in filling out an application form. _____ **(Initial)**

**Additional Charges**
A fee of $30 will be charged on all returned checks. _____ **(Initial)**

**Cancellation Policy – 24 Hours' Notice**
If you are unable to keep an appointment, we ask that you kindly provide us with a minimum of 24 hours' notice. If less than 24 hours' notice is given, there will be a $75 broken appointment fee per appointment that is canceled or missed. Our office does not accept cancellations or changes in appointments via email, text, or after hours by voice mail; you **must** call during our normal business hours. This courtesy on your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist._____ **(Initial)**

_____
**PRINT PATIENT NAME**

_____ _____
**PATIENT SIGNATURE** **DATE**
(PARENT / GUARANTOR signature if patient is a minor)

Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, PHI restricted by law, information that is related to research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**You have the right to request a restriction of your protected health information** - This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your requested restriction except if you request that we not disclose PHI to your health plan with respect to healthcare for which you have paid in full out of pocket

**You have the right to request to receive confidential communications** - You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You have the right to request an amendment to your protected health information** - This request must be made in writing and we have 30-days to reply. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. We may deny amending your PHI if we did not create the information or if the treating provider who created the infonnation is no longer available to make the amendment

**You have the right to receive an accounting of certain disclosures** - You have the right to receive an accounting (listing) of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request

**You have the right to receive notice of a breach** - We would notify you If your unsecured PHI held by our practice or a business associate has been breached. "Unsecured" is information that is not secured through the use of technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the PHI unusable, unreadable, and undecipherable to unauthorized users.

**You have the right to obtain a paper copy of this Notice from us even if you have agreed to receive the Notice electronically.** We will also make available copies of our new Notice if you wish to obtain one.

**We reserve the right to change the terms of this Notice.** The new Notice will be available upon request, posted in our office, and on our website.

**COMPLAINTS AND QUESTIONS**

You may file a complaint with us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You will not be penalized for filing a complaint.

If you have any questions or wish to file a complaint, please contact us at:

Dr. Jeffrey Wert
1152 Main Street Hellertown,
PA 18055
610-748-7001
info@sauconvalleydental.com

U.S. Department of HEalth & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Room 515 F HHH Building
Washington, DC 20201
www.hhs.gov/ocr

**Dr. Jeffrey Wert**

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN ACCESS YOUR INFORMATION. PLEASE READ IT CAREFULLY.**

## ABOUT THIS NOTICE

This Notice of Privacy Practices describes how we, our Business Associates, and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO), and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" includes demographic information, that may identify you and relates to your past, present, or future physical or mental health condition and related health care services including dental care.

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice.

This Notice takes effect 2/16/2026. We reserve the right to make updates. Updated Notices will be available in our office as well as on our website at: www.sauconvalleydental.com

## USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by our office and others outside of our .office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of our practice, and any other use required by law. Please see descriptions and examples below. Some information, such as HIV related information, genetic information, alcohol and/or substance use disorder treatment records and mental health records may be entitled to special confidentiality protections under applicable state or federal law we will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your care and any related services. For example, we may disclose your health information to a medical/dental specialist providing treatment to you, including referrals.

Payment: Your health information will be used, as needed, to obtain payment for your services. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, your insurance company, or another third party. For example, we may send claims to your health plan containing certain health information as applicable for our practice or share limited information with authorized parties to resolve a balance di  pute.

Healthcare Operations: We may use or disclose your protected health information as needed, to support the business activities of our practice. These activities include, but are not limited to, quality assessment, employee review, training of interns, licensing, billing services, and other business activities. We may also use a sign-in sheet, call you by name in the waiting room, or send reminders via phone, email, or text, related to appointments, payment, or treatment alternatives or other health  related benefits and services that may be of interest to you. You may choose to opt out We may take intra oral, facial photos, or digital s  ans for treatment-related purposes.

We may also use authorized Artificial Intelligence (AI) programs to support clinical decision-making, enhance diagnostic accuracy, and improve your oral health outcomes. These tools are used in accordance with applicable privacy laws and are designed to protect your personal health information. For example, we may use AI to document clinical notes or assist in analyzing dental images or identifying treatment options based on your clinical data.


# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Since Saucon Valley Dental PLLC is a HIPAA covered office, our office policy requires you to sign this acknowledgment. If you do not wish to sign this acknowledgment, we are not comfortable seeing you in our office and you will have to locate another dentist.

I, _____,

have received a copy of this office's Notice of Privacy Practices. A copy of this signed and dated Acknowledgement shall be as effective as the original. **My signature will also serve as a Protected Health Information (PHI) document release should I request documents be sent to other attending doctor / treatment facilities in the future.**

_____
(Signature)

_____
(Date)

**For Office Use Only**

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)

_____

SAUCON VALLEY DENTAL

# Third Party Authorization

Here at our office we are committed to the protection of your personal information. In order to discuss your dental health and/or treatment plans with or release information to **third parties**, this form must be completed and signed. Please include the names of all individuals that you want to have access to your dental records and/or treatment plans. **If you do not want a third party contact(s) on file, please leave this form blank.**

Name: _____
Phone #: _____
Relationship: _____

Name: _____
Phone #: _____
Relationship: _____

**I, _____, hereby authorize Saucon Valley Dental PLLC to have verbal and/or written communication with the above stated individual(s). This authorization will remain in effect until I submit a written letter or email to Saucon Valley Dental PLLC, terminating my consent.**

**Signature: _____ Date: _____**