Dzuban Dental Associates

300 Penn Center Blvd #210
Pittsburgh, PA 15235
412-825-0200
Fax 412-825-4627

Patient Name _____

Email _____ Cell _____ Home _____

Street Address _____ City _____ Zip _____

Date of Birth ____/____/____ ☐ Male ☐ Female

Insurance

Name of Dental Insurance _____

Policy Holder for Dental _____ Relationship to Insured ☐self ☐spouse ☐child

Employer _____

Name of Medical Insurance _____

Policy Holder for Medical _____ Relationship to Insured ☐self ☐spouse ☐child

Physician Name _____ Phone # _____

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving it blank will indicate a "NO" response.

☐ Pre-Med	☐ Acid reflux/GERD	☐ ADD/ADHD	☐ AIDS/HIV
☐ Allergy-Celiac/Gluten	☐ Allergy to Medicine	☐ Allergy-Latex	☐ Allergy-Penicillin
☐ Angina	☐ Anxiety/Depression	☐ Arrythmia (Afib)	☐ Arthritis
☐ Artificial Joints	☐ Asthma	☐ Back Problems	☐ Blood Pressure-High
☐ Blood Pressure-Low	☐ Cancer	☐ Chemical Dependency	☐ Chemotherapy
☐ Circulatory Problems	☐ Diabetes	☐ Dizziness/Fainting	☐ Epilepsy/Seizures
☐ Excessive Bleeding	☐ Fibromyalgia	☐ Glaucoma	☐ Head injuries
☐ Headaches	☐ Heart Disease	☐ Heart Murmur	☐ Hemophilia
☐ Hepatitis	☐ High Cholesterol	☐ Jaw Pain	☐ Kidney Disease
☐ Liver Disease	☐ Memory Loss	☐ Mental Illness	☐ Mitral Valve Prolapse
☐ Nervous Disorders	☐ Organ Transplant	☐ Osteoporosis	☐ Pacemaker
☐ Pregnancy	☐ Radiation Treatments	☐ Respiratory Problems	☐ Shortness of Breath
☐ Sinus Problems	☐ Sjogrens	☐ Skin Rash	☐ Stent
☐ Sleep Apnea	☐ Sleep Apnea-CPAP	☐ Snore	☐ Stomach Problems
☐ Stroke/TIA	☐ Swelling/Feet/Ankles	☐ Thyroid Problems	☐ Tobacco Habit
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Valve Replacement
☐ Hospitalized	☐ Under Doctor care	☐ Oral Surgery	☐ Vaping
☐ Bite Appliance	☐ Orthodontic Treatment		

(OVER)

Do you take antibiotic premedication for your dental visits? _____YES _____No If yes, please explain.

PRE-MED _____

Are you currently taking any medications, prescription and/or non-prescription? _____YES_____NO If yes, please explain.

MEDICATIONS

_____

_____

Do you have any allergies? _____YES _____NO

ALLERGIES

_____

_____

Describe any current medical treatment or impeding surgery that may possibly affect your dental treatment.

_____

_____

☐ By checking this box, I acknowledge that I have reviewed ALL questions on this questionnaire and responded accordingly. There are no other medical conditions/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

General Dental Treatment Consent Form

I authorize dental treatment including necessary or advisable examination, radiographs (x-rays), diagnostic aids or local anesthesia.

In general terms, dental treatment may include but is not limited to one or several the following:

- Administration of local anesthesia
- Cleaning of the teeth and application of topical fluoride
- Scaling and root planing with local anesthesia
- Application of sealants to the grooves of the teeth
- Treatment of diseased or injured teeth with dental restorations
- The replacement of missing teeth with a dental prosthesis (crown, partials, etc.)
- Treatment of malposition (crooked) teeth and/or developmental abnormalities
- Treatment of the canal or pulp chamber that lies in the middle of the tooth and its root also know as "endodontic" therapy or root canal

Risk of Dental Procedures In General

Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth. Thrombophlebitis (inflammation to a vein) reaction to injections, change in occlusion (biting), muscle cramps and spasms. Temporomandibular jaw (TMJ) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues. Referred pain to the ear, neck and head, nausea, allergic reactions, itching, bruises, delayed healing, sinus complications and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs; thus it is advisable not to operate any vehicle or hazardous device or work for twenty-four hours or until recovered from their effects.

Changes in Treatment Plan

I understand that during treatment, it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I will give my permission to the dentist to make any/all changes and additions, as necessary.

Fillings

I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. If my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs.

Crowns (Caps), Bridges and Onlays

I understand that sometimes it is not possible to perfectly match the color of artificial teeth with natural teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes to my new crown or bridge (including shape, fit, size, and color) will be before cementation. Once cemented, I understand that any changes in shape, fit, size or color will incur an additional charge.

Alternative Treatment

I understand that I have the right to choose, based on adequate information, from alternate treatment plans that meet professional standards of care.

By signing below, I consent to the general treatments and/or proposed treatment.

Patient/Guardian Signature: _____ **Date:** _____

Patient Name (Printed): _____

About HIPAA Privacy

The Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

Your Health Information is Protected by Federal Law

Most of us believe that our medical and other health information is private and should be protected, and we want to know who has this information. The Privacy Rule, a Federal law, gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

What Information is Protected?

- Information your doctors, nurses, and other health care providers put in your medical record
- Conversations your doctor has about your care or treatment with nurses and others
- Information about you in your health insurer's computer system
- Billing information about you at your clinic
- Most other health information about you held by those who must follow this law

How is This Information Protected?

- Covered entities must put in place safeguards to protect your health information.
- Covered entities must reasonably limit uses and disclosures to the minimum necessary to accomplish their intended purpose.
- Covered entities must have contracts in place with their contractors and others ensuring that they use and disclose your health information properly and safeguard it appropriately.
- Covered entities must have procedures in place to limit who can view and access your health information as well as implement training programs for employees about how to protect your health information.

What Rights Does This Law Give Me Over My Health Information?
Health Insurers and Providers who are covered entities must comply with your right to:

- Ask to see and get a copy of your health records
- Have corrections added to your health information
- Receive a notice that tells you how your health information may be used and shared
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as for marketing
- Get a report on when and why your health information was shared for certain purposes
- If you believe your rights are being denied or your health information isn't being protected, you can:
    - File a complaint with your provider or health insurer
    - File a complaint with the U.S. Government

You should get to know these important rights, which help you protect your health information. You can ask your provider or health insurer questions about your rights.

Who Can Look at and Receive Your Health Information
The law sets rules and limits on who can look at and receive your health information. To make sure that your health information is protected in a way that does not interfere with your health care, your information can be used and shared:

- For your treatment and care coordination
- To pay doctors and hospitals for your health care and to help run their businesses
- With your family, relatives, friends, or others you identify who are involved with your health care or your health care bills, unless you object
- To make sure doctors give good care and nursing homes are clean and safe
- To protect the public's health, such as by reporting when the flu is in your area
- To make required reports to the police, such as reporting gunshot wounds

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer
- Use or share your information for marketing or advertising purposes
- Share private notes about your health care

Personal Health Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

[ ] I authorize the release of any and all information including diagnosis, financial, dental records, examinations rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

COVID-19 Update (for website)

While many things have changed, one thing has remained the same: our commitment to your safety. Infection control has always been a top priority for our practice and you may have seen this during your visits to our office. We have made the following changes to help protect our patients and staff.

- Our office will ask COVID -19 screening questions when confirming your appointment day and time.
- We ask that you call the office (412-825-0200) from your car to let our staff know that you have arrived so as to limit the number of patients in our waiting area.
- Please wear a mask into the building as well into our office and come alone if at all possible.
- Staff will take your temperature upon arrival.
- Hand sanitizer is available throughout the office for your use.
- You will be asked to rinse with a pre-rinse before starting your dental procedure
- The doctors, assistants, and hygienists are wearing extra protective equipment (N95 masks, face shields and gowns) for the safety of everyone.