James R. Werkmeister DMD, MS
Jennifer M. Zavoral DMD, MPH

**Periodontics with a Caring Touch**

1000 Brooktree Rd Suite 304 Wexford PA 15090- Phone (724) 933-0070    4328 Northern Pike Suite 102 Monroeville PA 15146 Phone (412) 856-8200

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Date ____________ SSN ______________________________

Name ______________________________________ Birthdate ____/____/____

Address ______________________________________________________________

City ________________________________ State __________ Zip code __________

Patient Employed by ________________________________ Occupation ________________

Business Address ______________________________ Work Phone ______________ ☐ ok to call ☐ don't call

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Home Phone ______________ ☐ ok to call ☐ don't call

Referred by ____________________________________ Cell Phone ______________ ☐ ok to call ☐ don't call

Emergency contact __________________________________ Phone ______________________

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**PRIMARY DENTAL INSURANCE COVERAGE**

Person Responsible for Account ______________________________________________

Relationship to Patient ________________ Birthdate __________ SSN ______________________

Name of Employer ________________________ Work Phone ______________________________

Business Address __________________________ City ________________ State_____ Zip________

Insurance Company ____________________________________ Group # ____________________

Ins. Co. Address __________________________ City ________________ State_____ Zip________

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**SECONDARY DENTAL INSURANCE COVERAGE**

Subscriber Name ______________________________________________________________

Relationship to Patient ________________ Birthdate __________ SSN ______________________

Name of Employer ________________________ Work Phone ______________________________

Business Address __________________________ City ________________ State_____ Zip________

Insurance Company ____________________________________ Group # ____________________

Ins. Co. Address __________________________ City ________________ State_____ Zip________

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Signature of patient (or parent if minor) ____________________________________________

## Confidential Dental Health History

Date:________________

Patient Name ____________________________________________ Birthdate:____________

### Dental History

Reason for today's visit? ______________________________________________

Dentist? ______________________________________________

Address ______________________________________________

Date of last dental care?____________________ Date of last dental x-rays?____________________

How often do you floss? ____________________ How often do you brush? ____________________

### Medical History

Physician's Name: ______________________________ Date of last visit:____________________

Have you had any serious illnesses or operations? _______ Describe:____________________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate date: ____________

(WOMEN) Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No On birth control meds? ☐Yes ☐No

Check (✓) if you have had problems with any of the following:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | AIDS | | Cortisone treatments | | High blood pressure | | Scarlet Fever |
| | Anemia | | Persistent cough | | HIV positive | | Shortness of breath |
| | Arthritis, Rheumatism | | Cough up blood | | Jaw pain | | Skin Rash |
| | Artificial heart valves | | Diabetes Type: ____ | | Kidney disease | | Stroke |
| | Artificial joints | | Epilepsy | | Liver disease | | Swelling of feet/ankles |
| | Asthma | | Fainting | | Mitral valve problems | | Thyroid problems |
| | Back problems | | Glaucoma | | Nervous problems | | Tobacco Habit |
| | Blood disease | | Headaches | | Pacemaker | | Tonsillitis |
| | Cancer | | Heart Murmur | | Psychiatric care | | Tuberculosis |
| | Chemical dependency | | Heart problems | | Radiation treatment | | Ulcer(s) |
| | Chemotherapy | | Hemophilia | | Respiratory disease | | Venereal disease |
| | Circulatory problems | | Hepatitis | | Rheumatic Fever | | Other |

Notes:

| MEDICATIONS | | ALLERGIES |
|---|---|---|
| Current Medications: | | Aspirin |
| | | Barbiturates (sleeping pills) |
| | | Codeine |
| | | Local Anesthetic |
| | | Penicillin |
| Pharmacy name: | | Sulfa |
| Phone number: | | Other: |

The above information is accurate and complete to the best of my knowledge.
I will not hold Dr. Werkmeister or any member of his/her staff responsible
for any errors or omissions that I may have made in the completion of this form.

Signature:______________________________________ Date:________________

James R. Werkmeister, DMD, MS
Jennifer M. Zavoral, DMD, MPH
*Periodontics with a Caring Touch*

## Dental History

Name:____________________________________________
Address:____________________________________________
Who referred you to our office? __________________________________

**1. Chief Complaint**

What concerns do you have about your teeth?

**2. Symptoms**

Check all boxes that apply to your mouth

□ Hot Sensitive
□ Cold Sensitive
□ Loose Teeth
□ Cavities/Old Fillings
□ Missing Teeth
□ Painful Gums/Teeth
□ Other (describe)
□ Bad Bite
□ Popping/Clicking of Jaws
□ Painful Jaws
□ Food Packing between Teeth
□ Bad Breath
□ Bleeding Gums

**3. Motivation/Interest**

Motivation toward keeping your teeth

□ Highly motivated
□ Somewhat motivated
□ Not very motivated

My main interest in pursuing periodontal treatment is (check the most appropriate box)

□ Keeping my teeth to avoid dentures
□ Maintain a youthful appearance
□ Continue to eat the foods that I want
□ Avoid the health consequences of unrelated gum disease
□ Avoid dental pain
□ Because my dentist recommended it

**4. Your Dentist/Dental Care**

Dentist name:__________________________________________
Last dental visit:_______________________________________
How often do you see your dentist?______________________________
Previous periodontal care: __________________________________

**5. Oral Hygiene**

I brush my teeth_________times/day
I floss my teeth __________times/day
Do you use any special oral hygiene aids? (electric toothbrush, proxybrush etc...)

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**Periodontics with a Caring Touch**

## WE'RE CONCERNED ABOUT YOU

**We understand that you are unique and have unique concerns. You may also have special needs for treatment given your medical history. So that we can provide you with the best possible care, please check off the statements that apply to you.**

**Name:**______________________________

| | | Yes | No |
|---|---|---|---|
| 1. | I am nervous about being in a dental chair. | ___ | ___ |
| 2. | I have had a bad experience in a dental office chair. | ___ | ___ |
| 3. | I sometimes get dizzy lying back in a dental chair. | ___ | ___ |
| 4. | I have had difficulty with gagging or suctioning. | ___ | ___ |
| 5. | I would like to take breaks during long appointments. | ___ | ___ |
| 6. | My teeth and gums are very sensitive. | ___ | ___ |
| 7. | I don't like dental noises such as drilling or suctioning. | ___ | ___ |
| 8. | I don't like shots (or have had a bad experience with them). | ___ | ___ |
| 9. | I would like extra care to relieve pain. | ___ | ___ |
| 10. | I am not comfortable being lectured by doctors. | ___ | ___ |
| 11. | I will need to relay what you tell me to my spouse or another. | ___ | ___ |
| 12. | I have concerns about appointment scheduling. | ___ | ___ |
| 13. | I have concerns about the appearance of my teeth or smile. | ___ | ___ |
| 14. | I have concerns about eating, chewing, or bad breath. | ___ | ___ |
| 15. | I have concerns about insurance or finances. | ___ | ___ |
| 16. | I have another question or concern. (Please write it below). | ___ | ___ |

______________________________________________

**17. Please check off if you (or a family member) have a history of the following:**

| | | Yourself | Parents | Grandparents |
|---|---|---|---|---|
| A. | Alzheimer's Disease | ___ | ___ | ___ |
| B. | Blood Cancer | ___ | ___ | ___ |
| C. | Diabetes | ___ | ___ | ___ |
| D. | Heart Attack | ___ | ___ | ___ |
| E. | Heart Disease | ___ | ___ | ___ |
| F. | Kidney Cancer | ___ | ___ | ___ |
| G. | Lung Cancer | ___ | ___ | ___ |
| H. | Lung Disease | ___ | ___ | ___ |
| I. | Obesity | ___ | ___ | ___ |
| J. | Osteoporosis | ___ | ___ | ___ |
| K. | Pancreatic Cancer | ___ | ___ | ___ |
| L. | Premature Childbirth | ___ | ___ | ___ |
| M. | Stroke | ___ | ___ | ___ |
| N. | Tongue Cancer | ___ | ___ | ___ |
| O. | Other Cancers | ___ | ___ | ___ |
| P. | Tooth Loss/Dentures | ___ | ___ | ___ |

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

______________________________
{Please Print Name}

______________________________
{Signature}

______________________________
{Date}

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**For Office Use Only**

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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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

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James R. Werkmeister, DMD, MS
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# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**SECTION A: PATIENT GIVING CONSENT**

Name: ______________________________

Address: ______________________________

Telephone: ____________________ E-mail: ____________________

Patient Number: ____________________ Social Security Number: ____________________

**SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Jean Olshefski

Telephone: (724) 933-0070 Fax: (724)933-0077

E-mail: drjw@connecttime.net

Address: 1000 Brooktree Road, Suite 304 Wexford, PA 15090

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**SIGNATURE**

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: ______________________________ Date: ____________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**
**Include completed Consent in the patient's chart.**

**REVOCATION OF CONSENT**

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ______________________________ Date: ____________________

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## James R. Werkmeister, DMD, MS

## Jennifer M. Zavoral, DMD, MPH

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

**OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/03/2003), and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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## PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page and $25 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**Contact Officer:** Jean Olshefski
**Telephone:** (724) 933-0070
**Fax:** (724) 933-0077

**E-mail:** jwerkmeister@werkmeisterperio.com
**Address:** 1000 Brooktree Road, Suite 304, Wexford, PA 15044

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## WRITTEN FINANCIAL POLICY

Thank you for choosing us! Our mission is to deliver the best and most comprehensive periodontal care available. An important part of our mission is making your care as affordable and manageable as possible by offering several payment options.

**Payment Options:**

- Cash or check
- Visa / MasterCard / American Express / Discover
- 5% Pre-payment discount
  - A 5% discount will apply to all treatment that has been pre-paid one week prior to scheduled appointment date.
- Convenient Monthly Payment Plans from CareCredit*
  - Allow you to pay over 12 months time
  - Fixed payments, reduced APR

We require payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will be refunded for any treatment not performed.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and submit all necessary documentation in order for you to receive reimbursement for your treatment.

We charge $35.00 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the treatment you want and need.

*Subject to credit approval → for more information or to apply, visit www.carecredit.com

## OFFICE CANCELLATION POLICY

We strive to provide you with the very best periodontal care. We value our patients and respect their time, and our *Office Cancellation Policy* helps us do so.

When a patient does not show up for his or her appointment, arrives late, or cancels too closely to the scheduled time, we are unable to attend to the other patients in a timely manner. This policy is our attempt to ensure that all patients receive the dental care that they need.

**BROKEN APPOINTMENTS:**

- When a patient arrives more than 10 minutes past his/her scheduled appointment time
- When a patient does not show up for his/her scheduled appointment
- When a patient cancels less than 48 hours before his/her scheduled appointment

**TERMS AND CONDITIONS OF BROKEN APPOINTMENTS:**

- Patients are permitted one broken appointment per calendar year.
- Patients will be charged a fee for a broken appointment after the second occurrence.
- After two broken appointments, a patient will be required to pay in full for the appointment at the time of scheduling

I have read and understand the *Office Cancellation Policy* of the practice and agree to its terms and conditions. I also understand and agree that such terms maybe subject to change.

I, ________________________________ (print name), have received a copy of the Periodontics with a Caring Touch *Office Cancellation Policy.*

______________________________________________________________________

Signature of Patient                                                                Date