BETH Snyder DMD

Dear Patient,

We appreciate your interest in our dental practice. When you visit our office you will find a unique and relaxing environment. All of our treatment is designed to be permanent and to exceed all of your expectations. We utilize the most recent technology and techniques our industry has to offer. Our areas of specialty are aesthetic and functional dentistry.

♦Aesthetic dentistry: We use the best materials, laboratories and techniques available to achieve the best result. All dentists proclaim to offer "cosmetic services" but we have taken it to the next level. We have completed the highest level of training at the Las Vegas Institute and were honored by them for outstanding achievement.
Aesthetic dentistry includes:

whitening / zoom
porcelain veneers
smile rejuvenation
metal free dentistry

♦Functional Dentistry: When we perform functional dentistry we are improving a patient's bite, improving the way the muscles and joints work together and providing the proper aesthetics through the bite relationship. A more functional bite can improve your appearance, remove wrinkles and make you look 10 years younger.
Functional dentistry includes:

orthodontics / Invisalign
one-visit crowns
implant restorations
dentures/partials
Strickland Facelift Dentures™
periodontal therapy
TMJ / headache treatment
snoring / sleep apnea

Please bring any completed paperwork with you to your appointment. If you have any questions please feel free to call, a member of our team will be happy to help you.

Sincerely,

Beth L. Snyder, DMD LVIF, FAGD, FICCMO, Diplomate of the American Board of Dental Sleep Medicine
Lisa M. Perrotta, DMD

cosmetic and general dentistry
tmj therapy and sleep disorder dentistry

Beth Snyder DMD, LVIF, FAGD, FICCMO • 252 w swamp road, suite 25 • doylestown, pa 18901

phone 215-348-9922 • fax 215-230-4428 • www.bethsnyderdmd.com • office@bethsnyderdmd.com

Patient Number _____ A B C

HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____

Soc. Sec. # _____ If Patient is a Minor, give Parent's or Guardian's Name _____ TODAY'S DATE _____

Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____

RESIDENCE Street _____ Apt. # _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ Apt. # _____ City _____ State _____ Zip _____

HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ E-MAIL _____

PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ City _____ State _____ Zip _____ How Long _____

SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____ (LAST / FIRST / MIDDLE)

EMPLOYER _____ OCCUPATION _____ ( ) NO. YEARS EMPLOYED

SOC. SEC. # _____ BIRTHDATE _____

HOME PH. _____ CELL PH. _____

WORK PH. _____ E-MAIL _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY, STATE _____

HOME PH. _____ CELL PH. _____

WORK PH. _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____ E-MAIL _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name _____

Insurance Co. _____ E-MAIL _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic)		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth (ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐

Name of Previous Dentist:

City: State:

How do you feel about your teeth?

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.

FEAR of pain # LACK of concern #

COST of treatment # MISSING work time #

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For what?		
What MEDICATIONS are you currently taking?		
Have you ever taken Fen-Phen/Redux?	☐	☐
Are you PREGNANT?	☐	☐
Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	☐	☐

PLEASE ✔ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	YES	NO		YES	NO		YES	NO
AIDS/HIV Pos.	☐	☐	Fainting	☐	☐	Psychiatric care	☐	☐
Anaphylaxis	☐	☐	Food allergies	☐	☐	Rapid weight gain/loss	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Radiation treatment	☐	☐
Arthritis (Rheumatism)	☐	☐	Headaches	☐	☐	Respiratory disease	☐	☐
Artificial heart valves	☐	☐	Heart murmur	☐	☐	Rheumatic/scarlet fever	☐	☐
Artificial joints	☐	☐	Heart problems (please describe)	☐	☐	Shingles	☐	☐
Asthma	☐	☐	_____			Shortness of breath	☐	☐
Atopic (Allergy Prone)	☐	☐	Hemophilia (Abnormal bleeding)	☐	☐	Skin rash	☐	☐
Back problems	☐	☐	Herpes	☐	☐	Spina Bifida	☐	☐
Blood disease	☐	☐	Hepatitis	☐	☐	Stroke	☐	☐
Cancer	☐	☐	High blood pressure	☐	☐	Surgical implant	☐	☐
Chemical dependency	☐	☐	Jaw pain	☐	☐	Swelling of feet or ankles	☐	☐
Chemotherapy	☐	☐	Kidney disease or malfunction	☐	☐	Thyroid disease or malfunction	☐	☐
Circulatory problems	☐	☐	Liver disease	☐	☐	Tobacco habit	☐	☐
Cortisone treatments	☐	☐	Material allergies	☐	☐	Tonsillitis	☐	☐
Cough (persistent)	☐	☐	(latex, wool, metal, chemicals)			Tuberculosis	☐	☐
Cough up blood	☐	☐	Mitral valve prolapse	☐	☐	Ulcer/Colitis	☐	☐
Diabetes	☐	☐	Nervous problems	☐	☐	Venereal disease	☐	☐
Epilepsy	☐	☐	Pacemaker/heart surgery	☐	☐			

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin, Local Anesthetic, Erythromycin, Latex (balloons, gloves, etc.), Nitrous Oxide, Codeine, Penicillin

Are you aware of being allergic to any other medications or substances?

If yes, please list:

Is there any other Medical or Dental information that you feel I should know about?

FAMILY PHYSICIAN _____ PHONE _____ E-MAIL _____

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____

Stop Bang Sleep Test Questionnaire

Please answer all quesions	YES	NO
Snoring: Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	○	○
Tired: Do you often feel tired, fatigued or sleepy during daytime?	○	○
Observed: Has anyone observe you stopping breathing during your sleep?	○	○
Blood pressure: Do you have or are you being treated for high blood pressure?	○	○
BMI: Is your BMI more than 35kg/m^2?	○	○
Age: Are you over 50 years old?	○	○
Neck Cimrcumferce: Is your neck circumference greater than 40cm/15¾"?	○	○
Gender: Are you male?	○	○

Show Total ☐ is your score. Below 3 = low risk. 3 and above = high risk.

Epworth Sleepiness Scale (ESS) Sleep Test Questionnaire

	0	1	2	3
Please answer all quesions	**Would never doze**	**Slight chance of dosing**	**Moderate chance of dosing**	**High chance of dosing**
Sitting & reading	○	○	○	○
Watching television	○	○	○	○
Sitting inactive in public place, for example a theatre or meeting	○	○	○	○
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 quitely after lunch (when you've had alcohol)	○	○	○	○
In a car while stopped in traffic	○	○	○	○

Show Total ☐ is your score. Scores above nine indicate the need for a sleep specialist.

Name: _____ Date: _____

Notice of Privacy Practices

Beth Snyder, DMD, pc – 252 W. Swamp Rd, Suite 25 - Doylestown, PA 18901

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 01/01/2017, 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 applicable law permits such changes. 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 or 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 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.

Person 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 to Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter intelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of an 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).

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 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, $15.00 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 you 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: As of April 14, 2003, 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. If you request this accounting more than once in a 2-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.

QUESTIONS AND COMPLIANTS:

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 may also 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: Cindy Roach
Phone: 215-348-9922 Fax: 215-230-4428
Address: 252 W Swamp Road, Suite 25
Doylestown, PA 18901

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Beth Snyder, DMD, pc —Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. In addition to the copy we provide here for you, copies of the current notice may be obtained throughout our office.

BY SIGNING THIS FORM, I ACKNOWLEDGE THE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES.

SIGNATURE *Date*

PAYMENT AND APPOINTMENT CANCELLATION POLICY

PAYMENT
We make every effort to minimize the cost of your care. You can help by paying in full at each visit. You may request an estimate of the charges for any procedure prior to the start of work. Everyone benefits when there is a definite and clear financial agreement prior to treatment. To make your financial arrangement as easy as possible, we accept Checks, Cash, Money Order, Visa, MasterCard and American Express. Payment in full is due the day of treatment.

INSURANCE
Insurance claims* will be submitted to your carrier for all covered services. If your carrier has changed, it is your responsibility to notify us. We will be happy to file your insurance as a courtesy. We will also be happy to help explain your insurance benefits to you, but it is ultimately the patient's responsibility to know their insurance benefits and to make sure that their claims are paid in a timely manner. Your insurance is a contract between you, your employer, and the insurance company.

APPOINTMENT CANCELLATION POLICY
It is your responsibility to keep your appointment. If you are unable to keep an appointment, kindly give us at least 24 hours notice. Any appointment that is failed or canceled with less than 24 hours notice may result in a cancellation fee. Unless in cases of an emergency determined understandable, our office may refuse services if multiple appointments are broken during a calendar year (by not calling to cancel an appointment at least 24 hours prior to appointment time).
We also reserve the right to reschedule your appointment should we, ourselves, be unavailable to you. As in the situation of doctor being sick or other emergency situation.

I HAVE READ AND FULLY ACCEPT THE POLICIES STATED ABOVE.

SIGNATURE *Date*

*THIS SIGNATURE ON FILE IS MY AUTHORIZATION FOR THE RELEASE OF INFORMATION NECESSARY TO PROCESS ANY INSURANCE CLAIMS, AND THAT I ACCEPT FULL RESPONSIBILITY FOR ALL CHARGES INCURRED.