

Special Touch Dentistry

Patient's Name _____ Nickname _____
Date of Birth _____ Age _____ Female Male
Address _____ City, State, Zip _____
Home Phone _____ Patient Cell Phone _____
Caregiver's Name _____
Email _____ Cell Phone _____
Guardian's Name _____
Email _____ Cell Phone _____
Referred by Whom _____

Medical History

Have you had any history of, difficulty with, or diagnosis of any of the following:

- | | | | |
|---|---|---|---|
| YES NO | YES NO | YES NO | YES NO |
| <input type="checkbox"/> <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> <input type="checkbox"/> HIV +/-AIDS | <input type="checkbox"/> <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> <input type="checkbox"/> Immunizations | <input type="checkbox"/> <input type="checkbox"/> Ringworm |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> <input type="checkbox"/> Kidney | <input type="checkbox"/> <input type="checkbox"/> Seizures |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> <input type="checkbox"/> Latex allergy | <input type="checkbox"/> <input type="checkbox"/> Sex. Trans. Disease |
| <input type="checkbox"/> <input type="checkbox"/> Autism/PDD | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Liver | <input type="checkbox"/> <input type="checkbox"/> Sickle cell |
| <input type="checkbox"/> <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Measles/Mumps | <input type="checkbox"/> <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> <input type="checkbox"/> Bladder | <input type="checkbox"/> <input type="checkbox"/> Fainting | <input type="checkbox"/> <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> <input type="checkbox"/> Tobacco/Drug Use |
| <input type="checkbox"/> <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> <input type="checkbox"/> Growth Problems | <input type="checkbox"/> <input type="checkbox"/> Pregnancy (teens) | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> <input type="checkbox"/> Hearing | <input type="checkbox"/> <input type="checkbox"/> Previous Surgeries | <input type="checkbox"/> <input type="checkbox"/> Warts |
| <input type="checkbox"/> <input type="checkbox"/> Bones/Artificial Joints | <input type="checkbox"/> <input type="checkbox"/> Heart/ Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Previous Hospitalizations | <input type="checkbox"/> <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Hepatitis | | |

Medications _____

Allergies (Medications, foods, etc) _____

Name of Physician _____ Phone _____ Last Visit _____

Dental History

Previous Dentist _____ Date of Last Visit _____

Date of Last Dental X-Rays _____ Date of Last Dental Cleaning _____

- Do you have a current dental problem? Yes No
- Do you brush daily? Yes No
- Do you floss daily? Yes No
- Do you use a mouth rinse daily? Yes No
- Any history of dental or facial trauma? Yes No
- Any unhappy dental experiences? Yes No
- Any harmful habits (thumb-sucking, nail biting, pacifier, mouth breathing, grinding) Yes No

I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I authorize the staff at Special Touch Dentistry to perform such treatments, services, medications, local anesthesia, analgesia, and accepted behavior management techniques that may be necessary to correct any oral deficiency, abnormality, infection and/or disease. If any conditions are discovered in the course of treatment which, in the opinion of the doctors authorized by this consent, require procedures in addition to or different than those described, I also authorize the performance of these procedures. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained from treatment, I consent to the taking and publication of any photographs in the course of this treatment for the purpose of advancing dental education. I certify that I have read the above Consent and questions were answered to my satisfaction.

Patient's/Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____ 4/6/26



Special Touch
DENTISTRY
*Providing Special
 Care in a Special Way*

Special Touch Dentistry

Dental Insurance / Financial Responsibility Form

Patient Contact Information	Referring Agency Contact Information
Patient's Name:	Name of Agency:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone:	Primary Contact:
Patient's Social Security Number:	Contact Phone:
Patient's Date of Birth:	Alternate Phone:

Caregiver Name: _____

Contact Phone: _____

Alternate Phone: _____

Dental Insurance: _____

ID#: _____

Group # (if applicable): _____

DOB: _____

This office is happy to cooperate with individuals who are covered by dental insurance. We only ask that you carefully read your policy to be sure that you are fully aware of any restrictions that apply to the benefits provided. Dental insurance is a contract between the patient and the insurance company for reimbursing the cost of dental services. It is not a contract between the dentist and the insurance company.

I understand that I am financially responsible for all services rendered by the Dentist. I understand any co-payments, deductibles, and/or procedure cost not covered or denied by my insurance company, (including coverage termination prior to the date services are rendered) are my responsibility.

This Dental office is authorized to fill out and/or assist me to complete any and all insurance forms pertaining to services rendered.

 (Patient or Guardian Signature)

 (Date)

Special Touch Dentistry

Office Policies

Zero Balance Office: We do **NOT** bill patients - only Insurance Companies. Payment is due at the time of treatment. We accept cash, check, and major credit cards. We also have no interest and low interest payment plans through Care Credit. Please ask for information.

Recall Visit: Examinations and indicated x-rays are performed every 6 months, unless you tell us otherwise.

Work: Dental treatment may include sealants, white (composite) fillings, silver (amalgam) fillings, pulp treatment (root canal), crowns, bondings, and/or extractions. Please check with your insurance company prior to your visit to see what procedures are covered and whether you will have a co-pay or deductible the day the services are rendered. Our doctors develop a treatment plan to provide the BEST care for you and not based on what is covered by your insurance company.

Referrals or Insurance Forms: Required referrals or insurance forms must be brought in the day of your child's appointment or the visit will be rescheduled.

Emergencies: True emergencies involve severe pain, swelling or bleeding. We will do our best to accommodate true emergencies.

Leaving the Office: If you have a driver or a caretaker, please do not ask them to leave the office during your visit. Treatment plans sometimes change during the procedures and the doctor may need to speak with them too.

No Show Policy: We have a strict "no-show" policy in place. You must call us 24 hours in advance if you cannot make your appointment. Anyone who misses 3 appointments without calling 24 hours in advance will be dismissed from the practice.

Communication Policy: For your convenience, we will now confirm your appointments, initiate reminders and newsletters, and report office closures through email, text (cellular provider rates may apply), or by phone. You may opt-out of the text messaging service by sending STOP to the text message you received. By signing below, you are consenting to our communication policy.

Predeterminations: These are only estimates. Your insurance company will not provide us a 100% accurate fee until the work is completed and they receive your claim from us. We try to gather as much information as we can, but please remember that insurance is a contract between you and your insurance company.

By signing this form, you acknowledge that you have received this form and adhere to the office policies of Special Touch Dentistry.

Patient Name (please print clearly)

Date of Birth

Guardian/Caretaker Name (if applicable – please print clearly)

Signature of Patient/Guardian/Caretaker

Date

Email address (please print clearly)

Special Touch Dentistry

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)

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
- Individual physically unable to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

SPECIAL TOUCH DENTISTRY

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical and dental information about you may be used and disclosed and how you can get access to this information. The privacy of your health information is important to us.

Our Legal Duties

We are required by the Health Insurance Portability and Accountability Act (HIPAA), the HIPAA Omnibus Rule, the Health Information Technology for Economic and Clinical Health Act (HITECH), 42 C.F.R. Part 2 (for certain substance use disorder records), and other applicable federal and state laws to keep your protected health information (“PHI”) private. We must give you this Notice, which explains how we may use and share your information and what rights you have. We must follow the terms of this Notice while it is in effect. We may change our privacy practices and this Notice at any time, as allowed by law. Any changes will apply to all PHI that we maintain, including information created or received before the changes. If we make a significant change, we will update this Notice and make the new version available in our offices (and on our website, if we have one). You may request a paper copy of this Notice at any time, even if you agreed to receive it electronically.

How We Use and Disclose Your Health Information

We may use and disclose your health information for the following purposes without your written permission, as permitted by law.

- **Treatment** - We may use or share your information to provide, coordinate, or manage your dental care and related services. For example, we may share information with your pediatrician, another dentist, an oral surgeon, or a pharmacy involved in your care.
- **Payment** - We may use or share your information to obtain payment for services we provide. For example, we may share information with your health or dental plan to get prior authorization or to bill and collect payment.
- **Health Care Operations** - We may use or share your information for our “health care operations.” These activities help us run our practice and improve quality. Examples include:
 - Quality assessment and improvement activities.
 - Reviewing the competence and performance of our staff and providers.
 - Training of students and staff.
 - Accreditation, certification, licensing, and credentialing activities.

Your Authorization

Other uses and disclosures of your information that are not described in this Notice will be made only with your written authorization. If you give us written authorization, you may revoke it in writing at any time. Revoking your authorization will not affect any use or disclosure of your information that took place before we received your revocation.

Special Protections for Substance Use Disorder (SUD) Records

Some records that identify you as having or having had a substance use disorder (such as alcohol or drug use disorder), and that are created by or received from a federally assisted SUD treatment program, are protected by an additional federal law called 42 C.F.R. Part 2 (“Part 2”). When we receive or maintain SUD treatment records subject to Part 2, we generally must obtain your specific written authorization before we use or disclose those SUD records, unless Part 2 specifically allows the use or disclosure without authorization (for example, in a medical emergency, for certain audits and evaluations, or as otherwise permitted by law). A single written consent may allow the use and disclosure of SUD records for treatment, payment, and health care operations, similar to HIPAA. SUD records protected by Part 2 cannot be used or disclosed in most civil, criminal, administrative, or legislative proceedings against you unless (a) you provide written consent, or (b) a court issues an order that meets Part 2’s strict requirements. If we disclose your SUD records pursuant to your authorization or a court order, the recipient may not redisclose them unless you authorize that redisclosure or Part 2 allows it.

Other Uses and Disclosures Permitted or Required by Law:

Out-of-Pocket Payments

If you pay for a service in full out of pocket, you may request that we not disclose information about that service to your health plan. We will honor this request unless a law requires us to share that information.

Individuals Involved in Your Care or Payment

With your agreement (or when you do not object), we may share relevant information with a family member, friend, or other person involved in your care or payment for your care. If you are unable to agree due to incapacity or an emergency, we may use our professional judgment to determine what is in your best interest.

We may also use or disclose information to locate or notify a family member, personal representative, or another person responsible for your care about your location, general condition, or death.

Appointment Reminders and Communications

We may use or disclose your information to contact you with appointment reminders or to communicate about treatment options and other health-related benefits or services that may be of interest to you (for example, voicemail messages, postcards, emails, text messages, or letters).

Marketing and Sale of PHI

We will not use your PHI for marketing communications or sell your PHI without your written authorization, except as permitted by law. If we contact you to raise funds for our organization, you have the right to opt out of receiving further fundraising communications.

HIV-Related Information (Pennsylvania)

HIV-related information is specially protected under Pennsylvania law. We will not disclose HIV-related information about you without your specific written consent, except as the law allows or requires.

Abuse, Neglect, or Violence

We may disclose your information to appropriate authorities if we reasonably believe you are a possible victim of abuse, neglect, or domestic violence or the victim of another crime, as permitted or required by law.

Public Health and Health Oversight

We may disclose information for public health activities (such as disease reporting, product recalls, or preventing or controlling disease) and to health oversight agencies for activities authorized by law.

Legal Proceedings and Law Enforcement

We may disclose information in response to a court or administrative order, subpoena, discovery request, or other lawful process, but only as allowed by law. For SUD records, additional Part 2 requirements apply, and most disclosures for legal proceedings require your consent or a specific Part 2 court order. We may also disclose information to law enforcement officials for certain purposes such as identifying or locating a suspect, complying with a warrant, or reporting certain injuries, as permitted by law.

Serious Threat to Health or Safety

We may use or disclose information when necessary to reduce or prevent a serious threat to your health or safety or the health or safety of others, consistent with applicable law.

Specialized Government Functions and Inmates

We may disclose information for certain specialized government functions, such as military or national security activities, and to correctional institutions or law enforcement officials having lawful custody of an inmate or patient, as permitted by law.

Breach Notification

If a breach of unsecured PHI occurs and a risk assessment shows that your information has been compromised, we will notify you as required by law. We may also need to notify government authorities and, in some cases, the media.

Your Rights

You have the following rights concerning your PHI.

Right to See and Get Copies: You have the right to look at or get a copy of your health information, including an electronic copy when we maintain your information electronically, with limited exceptions. You must make a written request. We may charge a reasonable, cost-based fee for copies, staff time, and postage, as allowed by law.

You may also request that we send a copy directly to another person or entity you designate in writing.

Right to an Accounting of Disclosures: You have the right to request a list (“accounting”) of certain disclosures we have made of your health information in the six years before your request, not including disclosures for treatment, payment, health care operations, and certain other disclosures. If you request more than one accounting in a 12-month period, we may charge a reasonable, cost-based fee.

Right to Request Restrictions: You have the right to request additional restrictions on our use or disclosure of your information. We are not required to agree to all requested restrictions, but we must honor certain restrictions, such as those related to services you have paid for in full out of pocket.

Right to Request Confidential Communications: You have the right to request that we communicate with you in a specific way (for example, at work instead of at home) or at a specific location. Your request must be in writing and tell us how or where you prefer to be contacted. We will accommodate reasonable requests.

Right to Request an Amendment: If you believe that information we have about you is incorrect or incomplete, you have the right to request that we amend your record. Your request must be in writing and explain why the information should be changed. We may deny your request in certain circumstances (for example, if the information was not created by us or is already accurate and complete).

Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this Notice at any time, even if you agreed to receive it electronically.

How to Exercise Your Rights or Ask Questions: To exercise any of these rights, ask questions, or get more information about our privacy practices, please contact:

Special Touch Dentistry
Telephone: 215-508-4200
Fax: 215-969-0215

Complaints

If you believe we have violated your privacy rights or you disagree with a decision we made about your PHI, you may file a complaint with us using the contact information above. You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. We will provide you with the appropriate address upon request. We will not retaliate against you for filing a complaint.