Today's Date
_____

3933 LANE ROAD, PERRY TOWNSHIP, OHIO 44077-4902

PATIENT (ONLY) INFORMATION

Name: _____
First Middle Last

Street: _____

City / State / Zip Code: _____

Phone Home: [_____]_____ Cell Phone: [_____]_____

Email: _____

Date of Birth: _____ ☐ Male ☐ Female

Social Security #: _____ (for billing purposes only) ☐ Single ☐ Divorce

Spouse Name: _____ ☐ Married ☐ Widowed

Emergency Contact Name: _____ Phone [_____]_____

Employer: _____ Address: _____

Work Phone: [_____]_____ Work Email: _____

RESPONSIBLE PARTY (NOT THE PATIENT'S) INFORMATION ➔ PARENT OR GUARDIAN WHO BRINGS PATIENT TO THIS OFFICE

Name: _____
First Middle Last

Street: _____

City / State / Zip Code: _____

Phone Home: [_____]_____ Cell Phone: [_____]_____

Email: _____

Date of Birth: _____ ☐ Male ☐ Female

Social Security #: _____ (for billing purposes only) ☐ Single ☐ Divorce

Relationship to Patient: _____ ☐ Married ☐ Widowed

Employer: _____ Address: _____

Work Phone: [_____]_____ Work Email: _____

Today's Date _____

DENTAL HISTORY AND INFORMATION

How did you hear about us?

___MAILER/BROCHURE ___ COUPON ___ SIGNAGE
___NEWSLETTER ___RADIO ___SPORTS/TEAM
___PHONEBOOK ___ WEBSITE

___ANOTHER DENTIST: _____
___ PATIENT: _____
___ EMPLOYEE: _____
___ INSURANCE CARRIER: _____

What is the reason for today's visit? _____

Have you recently noticed anything unusual about your mouth, smile or teeth?

___Bad breathe ___Swollen / Red / Painful Gums ___Bleeding when brushing or flossing
___Loose or shifting teeth ___Food getting stuck between teeth ___Lumps / Bumps / Sores in your mouth

Do you experience frequent headaches which you feel might be jaw, mouth or tooth related? No Yes

Do you experience any of the following while chewing, eating opening or closing?

___Clicking ___Grinding noises ___Popping Sounds ___Difficulty or Pain with opening or closing
___Snoring ___Clenching ___Headaches when you wake up ___Sore Muscles in your face or neck

Please Explain: _____

Do you experience any sensitivity to: ___Chewing ___Cold ___Hot ___Sweets ___Pressure

Do you have teeth that are: ___Broken ___Chipped ___Cracked ___Crooked ___Discolored?

What dental treatments have you experienced in the past?

___Nothing ___Braces (Orthodontics) ___Caps, Crowns, Bridges, Veneers
___Extractions ___Oral Surgery ___Tooth Colored Fillings
___Gum (Periodontal) Therapy ___Root Canal Treatment
___Other: _____

Did you experience any trouble with those treatments?

_____

Do you have all of your teeth? No Yes

Have the missing teeth been replaced? No Yes Do you like how they were replaced? No Yes

Would you like information on ways (other) to replace them? No Yes

How would you like them to be replaced?

___Teeth that are glued in (BRIDGES or CROWNS) ___Teeth that are removable (DENTURES)
___Complete tooth replacement (IMPLANTS) ___Nothing

Do your teeth embarrass you? No Yes

What about your smile and teeth would you like to change? _____

_____

Do you have any other dental concerns or wishes? _____

Who was your previous Dentist? _____ Phone No.: [_____]_____

How long has it been since you've seen a Dentist? _____ What For? _____

When were x-rays taken last? _____ Type?_____

Why did you leave your last Dentist? _____

What did you like <u>most</u> about your last Dentist? _____

Have you ever had any bad experiences in a dental office? _____

Today's Date _____

MEDICAL HISTORY AND INFORMATION

- ❑ **ALLERGIES**
  - o Anesthetics
    - ▪ Epinephrine
    - ▪ Lidocaine
    - ▪ Marcaine
    - ▪ Novocaine
    - ▪ Septocaine
    - ▪ Other: _____
  - o Aspirin
  - o Amoxicillin
  - o Barbiturates
    - ▪ Phenobarbital
    - ▪ Other: _____
  - o Codeine
  - o Hydrocodone
  - o Erythromycin
  - o Latex
  - o Penicillin
  - o Sulfa Drugs
  - o Tylenol or Acetaminophen
  - o Valium
  - o Vicodin
  - o Other: _____
- ❑ **BONE and JOINT SITUATIONS**
  - o Artificial Joints
  - o Arthritis
  - o Painful or Swollen Joints
  - o Osteoporosis
  - o Other: _____
- ❑ **BREATHING SITUATIONS**
  - o Asthma
  - o Emphysema
  - o Shortness of Breath
  - o Sinus Problems or Sinusitis
  - o Tuberculosis, Exposure To
  - o Other: _____
- ❑ **CARDIAC AND HEART SITUATIONS**
  - o Angina, Chest Pain or pressure
  - o Bypass # _____
  - o Heart Attack
  - o Heart Disease
  - o Heart Murmur
  - o High Blood Pressure
  - o Low Blood Pressure
  - o Mitral Valve Prolapse
  - o Pacemaker
  - o Prosthetic Valves
  - o Stints or Shunts
  - o Other: _____
- ❑ **ENDOCRINE, KIDNEY, LIVER or STOMACH SITUATIONS**
  - o Difficulty in swallowing
  - o Diabetes
  - o Frequently Tired
  - o Kidney Disease or Problems
  - o Hepatitis or Jaundice
  - o Liver Disease or Problems
  - o Recent Weight Gain or Loss
  - o Stomach Problems or Ulcers
  - o Thyroid Problems
  - o Other: _____
- ❑ **IMMUNE SYSTEM SITUATIONS**
  - o AIDS / HIV / STDs
  - o Excessive or Lingering Infections
  - o Easily Bruised or Excessive Bleeding
  - o G6PD Deficiency
  - o Leukemia or Anemia
  - o Oral Sores or Ulcerations
  - o Other: _____
- ❑ **NEUROLOGICAL SITUATIONS**
  - o Depression
  - o Dizziness
  - o Epilepsy or Seizures
  - o Fear of the Dentist
  - o Frequent Headaches
  - o Numbness
  - o Stroke
  - o Other: _____
- ❑ **OTHER SITUATIONS**
  - o Blurred vision
  - o Cancer, Chemotherapy, Radiation Therapy
  - o Glaucoma
  - o Skin Rashes or Ulcerations
  - o Other: _____

Are you under the care of a Physician? **No** **Yes** Date of last visit _____

Physician's Name _____ Physician's Telephone #: [_____]_____

Please explain: _____

_____

Are you presently taking any medication (either over-the-counter or prescription)? **No** **Yes**

Please explain: _____

_____

Are you taking *Bisphosphonate Medications* for Osteoporosis, Bone Metastasis, Hypocalcaemia or Multiple Myeloma?

Oral Bisphosphonate Medications include: Actonel, Boniva, Didronel, Fosamx, Fosamax +D, Reclast, Skelid, Zometa

IV Bisphosphonate Medications include: Aredia, Bonefus, Zometa

Have you experienced any unusual reactions to any medications? **No** **Yes**

Please explain: _____

Social History:

Do you smoke? No Yes Packs per day _____ How long _____

Do you use alcohol No Yes Drinks per day _____ How long _____

Female Clients Only:

Are you using Birth Control Pills? No Yes Are you pregnant (or think you might be)? No Yes

Are you nursing? No Yes Expected due date: _____

Today's Date _____

WRITTEN FINANCIAL POLICY , TREATMENT AUTHORIZATION AND AGREEMENT

I certify that the above statements regarding my personal, dental and medical information are true and correct to the best of my knowledge.

I hereby authorize Perry Dental Solutions to release to my insurance company any necessary information acquired in the course of my dental care.

I authorize and give consent to any and all Perry Dental Solutions' Employees or Representatives to perform those dental treatments (**INCLUDING ANY X-RAYS or FLUORIDE TREATMENTS)** and related care, which are deemed necessary, as determined from a joint dialogue between myself {the Patient and/or Parent, Guardian, Responsible Party} and the Doctor.

I agree and understand, that as the Patient, the Parent, Legal Guardian or Responsible Party of this patient (child), with out regard to the patient's age, marital status, divorce decrees, child support court orders or any related external agreements, by signing below and/or by allowing Perry Dental Solutions to provide any dental treatment(s), I am accepting full responsibility for the payment of any and all fees incurred at this office.

Payment Options:

Cash; Personal or Business Check; Credit (Debit) Card: American Express, Discover, MasterCard, Visa; Dental Insurance

Installment Payment Plans through our financial partner company: CareCredit Healthcare Credit Card.

~ Monthly payments that fit into your budget
~ No annual fees or pre-payment penalties
~ Acceptable for balances or treatments over $300
~ Subject to credit approval

Payment of Dental Treatment fees is required at or before the time you receive your treatment. No treatment will be preformed without payment.

For patients with Dental Insurance:

- We will work with your insurance plan to maximize your yearly benefit;
- We will submit claims to your insurance plan for you and we will ask that they reimburse Perry Dental Solutions directly for your treatment;
- Pre-Treatment estimates, quotes and/or Insurance Pre-determinations are not a requirement for treatment. We will attempt to provide that information to you, to the best of our ability. If you receive any estimate, please understand that these are ONLY estimates and that your actual out-of-pocket balance, after any insurance payment have been posted to your account, may be different from the original estimate.
- If we have not received payment from your insurance company after 60 days from the day you received treatment, without any communication from them, the entire treatment fee will become your total and 100% responsibility to pay.

No Call/No Show Policy:

- If you do not call the practice to inform us that you are not showing up for your appointment, a *Broken Appointment Fee of $100.00* will be charged to your account. This fee must be paid before another appointment will be scheduled.
- If you do not call the practice to inform us that you are not showing up for your appointment a 2nd time, a *Broken Appointment Fee of $150.00* will be assessed to your account. This fee plus the entire cost for the procedure being performed at that appointment, must be paid before another appointment will be made for you. Any insurance benefit you may be eligible for will be paid directly to you.

36 Hour Cancelation Policy:

- If you call the practice within 36 hours of your appointment to cancel/reschedule your appointment, a BROKEN APPOINTMENT FEE will be assessed to your account as follows:

  1st Time: zero 2nd Time: $25.00 3rd Time: $50.00 4th Time: $75.00 5th Time: $100.00
- All broken appointment fees must be paid before another appointment will be made.
- In order to schedule an appointment after the 5th broken appointment, the entire appointment fee must be paid in full plus any broken appointment fees assessed to your account. Any insurance benefit you may be eligible for will be paid directly to you.
- If your appointment is on a Monday and you call over the Weekend (from Friday at 4:00pm till Monday at 7:59am) to cancel your appointment, you will be inside the 36 Hour Time Period and a Broken Appointment Fee will be assessed to your account.
- If you call prior to the 36 Hour Time Period before your appointment, no BROKEN APPOINTMENT FEE will be charged out to you.

_____ _____

PATIENT NAME (printed) RESPONSIBLE (GUARDIAN) PARTY NAME (printed)

_____ _____

PATIENT/PARENT/GUARDIAN/RESPONSIBLE PARTY (S) SIGNATURE DATE

Today's Date _____

NOTICE OF PRIVACY PRACTICES ➔ REVISED TO REFLECT THE 2013 HIPAA/HITECH OMNIBUS FINAL RULES

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation ☐ Work Phone Confirmation
☐ Text Message to my Cell Phone ☐ Email Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation ☐ Work Phone Confirmation
☐ Text Message to my Cell Phone ☐ Email Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ Text Message ☐ Email ☐ **Any of the Above** ☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____
PATIENT NAME (printed) RESPONSIBLE (GUARDIAN) PARTY NAME (printed)

_____ _____
PATIENT/PARENT/GUARDIAN/RESPONSIBLE PARTY (S) SIGNATURE Relationship of Legal Representative/Guardian to Patient

Your comments regarding Acknowledgements or Consents: _____

_____

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

☐ It was emergency treatment ☐ I could not communicate with the patient ☐ The patient refused to sign
☐ The patient was unable to sign because: _____
☐ Other (please describe): _____

_____
Signature of Privacy Officer Date

Today's Date _____

PATIENT UPDATES

Date	Provider	Update Information