

Welcome

Today's Date: _____

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____ Birth Date _____
Address _____ City _____ State _____ Zip _____
Sex M F Single Married Widowed Separated Divorced Minor
Hm Ph _____ Wk _____ Cell _____
Where is the best place to reach you? _____ Email Address _____
Patient Employed By _____ Occupation _____
Person to contact in case of emergency _____ Phone _____
May we ask how you found our office? _____

Responsible Party Information

Person Responsible For Account _____ Relation to Patient _____
Soc. Sec. # _____ Birth Date _____ Email Address _____
Address _____ City _____ State _____ Zip _____
Hm Ph _____ Wk _____ Cell _____ DL# _____
Where is the best place to reach you? _____ Is this person currently a patient in our office? Yes No

Primary Dental Insurance

Subscriber Name _____ Phone # _____
Relationship to Patient _____ DOB _____ Soc. Sec. # _____
Address _____ City _____ State _____ Zip _____
Person Responsible Employed By _____ Occupation _____
Insurance Company _____
Address _____ City _____ State _____ Zip _____
Phone # _____ Group # _____
Annual Maximum _____ Deductible _____ Used _____

Additional Dental Insurance

Does Patient Have Additional Coverage? Yes No If yes, please complete below.

Subscriber Name _____ Phone # _____
Relationship to Patient _____ DOB _____ Soc. Sec. # _____
Address _____ City _____ State _____ Zip _____
Person Responsible Employed By _____ Occupation _____
Insurance Company _____
Address _____ City _____ State _____ Zip _____
Phone # _____ Group # _____
Annual Maximum _____ Deductible _____ Used _____

Over Please

Patient Dental History

Are you currently experiencing any dental discomfort? Yes No

If so, please explain _____

Previous Dentist's Name _____

Phone # _____

Date of last dental care _____

Date of last x-rays _____

Please check (✓) Yes or No if you have had problems with any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad breath | <input type="checkbox"/> Y <input type="checkbox"/> N Frequent headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold |
| <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot |
| <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets | <input type="checkbox"/> Y <input type="checkbox"/> N Sores or lumps in mouth | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting |
| <input type="checkbox"/> Y <input type="checkbox"/> N Wear partials or dentures | <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding during brushing/flossing | <input type="checkbox"/> Y <input type="checkbox"/> N Previous orthodontic treatment |

Patient Medical History

Physician's name _____

Phone # _____

Date of last visit _____

Have you had any serious illnesses or operations? Y N

If yes, please describe _____

Are you currently under physician care? Y N If yes, please describe _____

Are you currently taking any medications? Y N If yes, please describe _____

Have you ever had a blood transfusion? Y N If yes, please give approx. dates _____

Have you ever taken Phen-Fen/ Redux? Y N

Women Only: Are you pregnant or trying to get pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Are you allergic to any of the following? Yes No If yes, please mark accordingly.

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other If yes, please explain: _____

Please check (✓) Yes or No whether you have had any of the following:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Recent weight gain/loss |
| <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease | <input type="checkbox"/> Y <input type="checkbox"/> N Heart disease/problems | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Joint replacement | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever | <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes/HPV | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida |
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive | <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis/Jaundice | <input type="checkbox"/> Y <input type="checkbox"/> N STD |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergies/Hay fever | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N High/Low blood pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Stomach troubles/ulcers |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis | <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy/Seizures | <input type="checkbox"/> Y <input type="checkbox"/> N Leukemia | <input type="checkbox"/> Y <input type="checkbox"/> N Swollen feet/ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Angina | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease/problem |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis/Rheumatism | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature _____

Date _____

Doctor's Comments/Signature _____

Date _____

Laury DiMichaelangelo, Lisa Johnson & Mickey Harrison, Inc.

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: Pam DiMichaelangelo
Telephone: 614-267-5000 Fax: 614-267-0541
E-mail: nodq@sbcglobal.net
Address: 3974 Karl Road

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 health 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: _____