# Welcome!

## About You

**Today's Date:**_____

**Name:**_____ **I prefer to be called:**_____

**Birthdate:**_____/_____/_____ **Social Security #:** _____-_____-_____ **Male or Female**

**Address(Apt#)/City/State/Zip:**_____

**Home Phone #:**_____ **Work Phone #:** _____

**Cell Phone #:** _____ **Email Address:**_____

**How would you prefer us to contact you ?** _____ **When is the best time?** _____

**Whom may we thank for referring you?** _____

**Employer:** _____ **Occupation:** _____

**Spouse's Name:** _____ **Daytime Phone #:** _____

## Emergency Contact Person

**His/Her Name:**_____ **Relation:** _____ **Home Phone #:**_____

**Address:** _____ **Work Phone #:**_____

# Middleburg Heights Family Dentistry Medical History

Name of personal physician: Date of last visit:

Your current physical health is: Good Fair Poor Currently under a physician's care? : Yes No

## Are you allergic to any of the following?

(circle all that apply)

| | | |
|---|---|---|
| Aspirin | Erythromycin | Sedatives |
| Codeine | Jewelry | Sulfa Drugs |
| Latex | Penicillin | Tetracycline |
| Dental Anesthetics | Other | |

## Are you taking any of the following?

(circle all that apply)

| | | |
|---|---|---|
| Antibiotics | Aspirin | Blood Pressure Meds |
| Blood Thinners | Digitalis/Heart Meds | Insulin/Diabetes Meds |
| Steroids | Thyroid Meds | Tranquilizers/Anti-Depressant |

List any other prescription medications:

## Do you have or have you experienced any of the following?

(circle all that apply)

| | | |
|---|---|---|
| Abnormal Bleeding | Arthritis | Artificial Bones/Joints |
| Artificial Valves | Asthma | Cancer |
| Chemotherapy/Radiation | Colitis/Crohn's | Congenital Heart Defect |
| Diabetes | Difficulty Breathing | Dry Mouth/Sjorgen's Syndrome |
| Emphysema | Epilepsy/Seizures | Frequent Headaches |
| Heart Attack | Heart Surgery | Hepatitis |
| High Blood Pressure | HIV/AIDS | Kidney Problems |
| Liver Disease | Low Blood Pressure | Osteoporosis |
| Pacemaker | Rheumatic Fever | Scarlet Fever |
| Sinus Problems | Stroke | Thyroid Problems |
| Tuberculosis (TB) | Ulcers | Snoring/Sleep Apnea |

List any other conditions:

1. Do you smoke or use tobacco in any form? Yes No
2. Have you ever taken Bisphosphonate drugs, such as Fosamax or Boniva? Yes No
3. Has it ever been recommended that you take an antibiotic prior to a dental visit? Yes No

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

Print Name _____ Date: Signature: _____

# Middleburg Heights Family Dentistry

## Insurance Information

Insurance Company: _____ Phone: _____

Address: _____

Group #: _____

Policy Holder's Name: _____

Policy Holder's Employer: _____

Policy Holder's SS# or ID#: _____

Policy Holder's Birthdate: _____

Relationship to Patient: _____

Is the patient covered by additional insurance? YES NO

Do you want your insurance company to pay Middleburg Heights Family Dentistry directly? YES NO

**Assignment and Release**

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to *Middleburg Heights Family Dentistry* all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

**Responsible Party Signature**

**Office Use Only:**

**Identification checked by staff? Initials :** _____

# Middleburg Heights Family Dentistry

# Financial Policy

Dear Patient:

In an effort to reduce costs, increase efficiency, and maintain a higher level of professional care, we have created a financial policy for both our patients and office personnel:

Our payment policies are as follows:

- We accept payments by CASH, PERSONAL CHECK, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, and CARE CREDIT.

- As a courtesy, we will accept most insurance plans and will gladly submit you claim. We will collect estimated deductibles, co-payments, any estimated out of pocket portion, and secondary coverage at the time of service.

  **Initialed by Patient: _____**

- Although our office will assist you in processing you insurance claims, please understand it is your responsibility to satisfy any account balance due, regardless of the insurance determination of reimbursement.

- Please be aware insurance policies change often and it is your responsibility to notify us in the event of a change. We will do our best to collect information about your coverage, but ultimately you need to be aware of your policy limitations.

If you have any questions regarding these policies, please do not hesitate to speak to our office personnel. We are here to help you in every way possible.

**PLEASE ACKNOWLEDGE THAT YOU UNDERSTAND THE ABOVE POLICY**

Signature: _____ Date: _____

# Middleburg Heights Family Dentistry

## Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 "HIPPA", I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____

Relationship to Patient:_____

Signature:_____

Date:_____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

| Date: | Initials: | Reason: |
|---|---|---|