Welcome!

About Your Child

Today's Date:_____

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

Birthdate: ____/____/_____ **Age:** _____

Male or Female _____

Home Address: _____

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

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

Whom may we thank for referring you? _____

Emergency Contact Person (if unable to contact parent)

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: