

# PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Home address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Billing address (if different): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_ Driver's license #: \_\_\_\_\_ State: \_\_\_\_\_

SS #: \_\_\_\_\_ Employer/Occupation: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_

Spouse's name & phone #: \_\_\_\_\_ Emergency phone # (other than spouse): \_\_\_\_\_

Primary dental insurance: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary dental insurance: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ SS #: \_\_\_\_\_

Name of your medical doctor: \_\_\_\_\_ Date of last visit to medical doctor: \_\_\_\_\_

Name of previous dentist: \_\_\_\_\_ Date of last visit to dentist: \_\_\_\_\_

Referred to us by: \_\_\_\_\_

## DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you had problems with previous dental treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you gag easily? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty in chewing your food? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew on only one side of your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid brushing any part of your mouth because of pain? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed easily? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you floss? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums feel swollen or tender? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever noticed slow-healing sores in or about your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids? _____	<input type="checkbox"/>	<input type="checkbox"/>
Cold foods or liquids? _____	<input type="checkbox"/>	<input type="checkbox"/>
Sours? _____	<input type="checkbox"/>	<input type="checkbox"/>
Sweets? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you take fluoride supplements? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you dissatisfied with the appearance of your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you prefer to save your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you want complete dental care? _____	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
How often do you brush? _____		
How often do you floss? _____		
Does your jaw make noise so that it bothers you or others? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind your jaws frequently? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your jaws ever feel tired? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does your jaw get stuck so that you can't open freely? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does it hurt when you chew or open wide to take a bite? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have earaches or pain in front of the ears? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any jaw symptoms or headaches upon awaking in the morning? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you find jaw pain or discomfort extremely frustrating or depressing? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a temporomandibular (jaw) disorder (TMD)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pain in the face, cheeks, jaws, joints, throat, or temples? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you unable to open your mouth as far as you want? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of an uncomfortable bite? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a blow to the jaw (trauma)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you a habitual gum chewer or pipe smoker? _____	<input type="checkbox"/>	<input type="checkbox"/>

# MEDICAL HEALTH HISTORY:

**Do you have, or have you had, any of the following?**

	Yes	No
Heart Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure problem _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve problem _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking heart medication _____	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker _____	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds _____	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease (anemia) _____	<input type="checkbox"/>	<input type="checkbox"/>
Ever require a blood transfusion? _____	<input type="checkbox"/>	<input type="checkbox"/>
Allergy Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking allergy medication _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers _____	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain or loss _____	<input type="checkbox"/>	<input type="checkbox"/>
Special diet _____	<input type="checkbox"/>	<input type="checkbox"/>
Constipation/Diarrhea _____	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Bone or Joint Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
Back or neck pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement _____	<input type="checkbox"/>	<input type="checkbox"/>
(e.g., total hip, pins, or implants)		
Fainting Spells, Seizures, or Epilepsy _____	<input type="checkbox"/>	<input type="checkbox"/>
Stroke(s) _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough or swollen glands _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Premedications required by physician</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Tumor _____	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Urinate more than 6 times a day _____	<input type="checkbox"/>	<input type="checkbox"/>
Thirsty or mouth is dry much of the time _____	<input type="checkbox"/>	<input type="checkbox"/>
Family history of diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or other respiratory disease _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
Do you smoke? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
Hepatitis, jaundice, or liver trouble _____	<input type="checkbox"/>	<input type="checkbox"/>
Herpes or other STD _____	<input type="checkbox"/>	<input type="checkbox"/>
HIV-positive/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses? _____	<input type="checkbox"/>	<input type="checkbox"/>
History of head injury? _____	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or other neurological disease? _____	<input type="checkbox"/>	<input type="checkbox"/>
History of alcohol or drug abuse? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any disease, condition, or problem not listed previously that you feel we should know about? _____		
If so, please describe: _____		

**During the past 12 months, have you taken any of the following?**

	Yes	No
<b>Antibiotics or sulfa drugs</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Anticoagulants (e.g., Coumadin)</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>High blood pressure medicine</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Tranquilizers</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Insulin, Orinase, or similar drug</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Aspirin</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Digitalis or drugs for heart trouble</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Nitroglycerin</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cortisone (steroids)</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Natural remedies</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Nonprescription drug/supplements</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other</b> _____		

**Are you allergic, or have you reacted adversely, to any of the following?**

	Yes	No
<b>Local anesthetics ("Novocaine")</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Penicillin or other antibiotics</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Sulfa drugs</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Barbiturates, sedatives, or sleeping pills</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Aspirin, Acetaminophen, or Ibuprofen</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Codeine, Demerol, or other narcotics</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Reaction to metals</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Latex or rubber dam</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other</b> _____		

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

**Women**

	Yes	No
<b>Are you taking contraceptives or other hormones?</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Are you pregnant?</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>If so, expected delivery date:</b> _____		
<b>Are you nursing?</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Have you reached menopause?</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>If so, do you have any symptoms?</b> _____		
_____		

Notes: \_\_\_\_\_

\_\_\_\_\_

Patient/Parent Signature: \_\_\_\_\_

Dentist Initial: \_\_\_\_\_

## HIPAA- PATIENT ACKNOWLEDGEMENT FORM

Olentangy Modern Dental's Notice of Privacy Practices (NOPP) provides information about how we may use and disclose protected health information (PHI) about you. The practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). The NOPP contains a Patient Rights section describing your rights under the law. Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. In the event that the terms of the Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment and office procedures. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or office procedures.

I give permission for Olentangy Modern Dental to leave a message or an email regarding an appointment at:

Home: \_\_\_\_\_ and/or

Cell: \_\_\_\_\_ and/or

Work: \_\_\_\_\_ and/or

Email: \_\_\_\_\_

I give permission for Olentangy Modern Dental to share medical/dental information with:

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

3. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

I assume responsibility to inform the practice of any changes in the above information.

Patient's Name (please print): \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient or Patient's Legal Guardian: \_\_\_\_\_

# Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Olentangy Modern Dental, is committed to preserving the privacy and confidentiality of your health information. This Notice of Privacy Practices describes how we may use and disclose your protected health information, referred to as "PHI," to carry out treatment, payment or office procedures and for other purposes that are permitted or required by law. This notice is effective 11/01/17. You may access or obtain a copy according to the following options: 1) our website at [www.olentangymoderndental.com](http://www.olentangymoderndental.com) 2) contact the office and request a copy to be sent to you by mail or email, 3) request a copy at the time of your next appointment.

**Get an electronic or paper copy of your medical/dental record:** You can ask to see or get an electronic or paper copy of your PHI. Ask us how to do this. We will provide a copy or a summary of your health information within 30 days of your request. We may charge a reasonable fee.

**Ask us to amend your medical record:** You have the right to request we amend your health information that you believe to be incomplete or incorrect. We may deny your request, but we will provide you an explanation in writing within 60 days.

**Request confidential communications:** You can ask us to contact you in a specific way (for example, home, office or cell phone) or to send mail to a different address. We will accommodate all reasonable requests.

**Ask us to limit what we use or share:** You can ask us not to use or share certain health information for treatment, payment or office procedures. We are not required to agree to your request, and we may say "no" if it would affect your care.

If you pay for a service or healthcare item out of pocket, in full, you can ask us not to share that information for the purpose of payment or our operations with your insurance provider.

**Get a list of those with whom we've shared information:** You can ask for a list (accounting) of the times we've shared your PHI for six (6) years prior to the date you ask, who we shared it with and why. We will include all disclosures except for those about treatment, payment and office procedures, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for

free but may charge a reasonable fee if you ask for another one within twelve (12) months.

**Get a copy of this privacy notice:** You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you:** If you have given someone medical power of attorney, that person can exercise your rights and make choices about your health information. We will make sure that person has authority and can act for you before we take any action.

**File a complaint:** You can file a complaint if you feel we have violated your rights by contacting:

Olentangy Modern Dental  
7100 Graphics Way, Suite 3800  
Lewis Center, OH 43035  
740-200-5100  
[hello@olentangymoderndental.com](mailto:hello@olentangymoderndental.com)

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20210, calling 877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hippa/complaints/](http://www.hhs.gov/ocr/privacy/hippa/complaints/).

We will not retaliate against you for filing a complaint.

**In these cases, you have both the right and choice to:**

- Share information with your family, friends, or others involved in your care.
- Share information in a disaster relief situation.
- Contact you for fundraising efforts.

If you are unable to tell us your preferences, we may go ahead and share your information if we believe it's in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

**In these cases, we never share your information unless you give us written permission:**

- Marketing purposes
- Sale of your information

**OTHER USES AND DISCLOSURES:** How do we typically use or share your PHI? We typically use or share PHI information in the following ways.

**Treatment of your child.** We can use your PHI and share it with other professionals who are treating him/her.

**Run our practice.** We can use and share your PHI to run our practice, improve your care and contact you when necessary.

**Bill for services.** We can use and share your PHI to bill and get payment from insurance plans or other entities.

**How else can we use or share your PHI?** We are allowed or required to share your information in other ways- usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see:  
[www.hhs.gov/ocr/privacy/hipaa/understanding/concon/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/concon/index.html)

**Help with public health and safety issues.** We can share PHI about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect or domestic violence and preventing or reducing a serious threat to anyone's health or safety.

**Comply with the law.** We will share information about you if state or federal laws require it, including the Department of Health and Human Services if it wants to see that we're complying with the federal privacy law.

**Work with a medical examiner or funeral director.** We can share information with a coroner, medical examiner or funeral director when an individual dies.

**Address law enforcement and other government requests.** We can use or share PHI for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law and for special government functions such as military, national security and presidential protective services.

**Respond to lawsuits and legal actions.** We can share PHI about you in response to a court or administrative order, or in response to a subpoena.

**OUR RESPONSIBILITIES:** We are required by law to maintain the privacy and security of your PHI. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your PHI other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

**CHANGES TO THE TERMS OF THIS NOTICE:** We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

**Olentangy Modern Dental**  
**7100 Graphics Way, Suite 3800**  
**Lewis Center, OH 43035**  
**740-200-5100**  
**hello@olentangymoderndental.com**

**FINANCIAL POLICY**  
**Olentangy Modern Dental**

**Assignment and Release**

I the undersigned, have insurance with \_\_\_\_\_, and assign directly to Olentangy Modern Dental all 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 the payment of benefits.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Signature of patient/parent/legal guardian

**Patient Agreement and Financial Policy**

I hereby agree to be responsible for the costs of care provided to me by Olentangy Modern Dental and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s).

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 48 hours prior to my scheduled appointment time. We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for your child. In return, we ask that you make every effort not to change your child's reserved dental appointment.

I understand that for any treatment less than two hundred and fifty dollars (\$250) payment in full is due at the time of service. I understand that after 60 days, any unpaid balance will incur a \$15 billing fee. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**Minor/Child Consent**

I, being the parent or legal guardian of \_\_\_\_\_, do here, by request and authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Signature of patient/parent/legal guardian