PATIENT INFORMATION

Welcome to Creekside Family Dental! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birth date_____

If minor, parent/guardian name _____

Home phone _____ Work phone _____ Cell phone_____

Emergency contact_____ Phone number_____ Relationship_____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____ ☐ Unmarried

Email_____

Whom may we thank for referring you to our office? _____

SUBSCRIBER INSURANCE INFORMATION:

Policy Holder Name_____ SSN _____ Policy Holder DOB ____/____/____

Address: _____ Employer_____ Phone # _____

Dental Insurance Co._____

Covered by secondary insurance? ☐ yes ☐ no

Secondary dental insurance company _____

Policy holder DOB _____ Social Security number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ☐ Cancer or tumor
- ☐ Heart ailment or angina
- ☐ Heart murmur, mitral valve prolapse, heart defect
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Artificial joint or valve
- ☐ High or low blood pressure
- ☐ Pacemaker
- ☐ Tuberculosis or other lung problems
- ☐ Kidney disease
- ☐ Hepatitis or other liver disease
- ☐ Alcoholism
- ☐ Blood transfusion
- ☐ Diabetes
- ☐ Neurologic condition
- ☐ Epilepsy, seizures, or fainting spells
- ☐ Emotional condition
- ☐ Arthritis
- ☐ Herpes or cold sores
- ☐ AIDS or HIV positive
- ☐ Migraine headaches or frequent headaches
- ☐ Anemia or blood disorders
- ☐ Abnormal bleeding after extractions, surgery, or trauma
- ☐ Allergies or hives
- ☐ Asthma

Do you smoke or use chewing tobacco? ☐ yes ☐ no

If yes, how much per day?

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

- ☐ Latex materials
- ☐ Penicillin or other antibiotics
- ☐ Local anesthetics
- ☐ Codeine or other narcotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Aspirin
- ☐ Other:_____

Are you taking any of the following?

- ☐ Aspirin
- ☐ Anticoagulants (blood thinners)
- ☐ Antibiotics or sulfa drugs
- ☐ High blood pressure medicine
- ☐ Antidepressants or tranquilizers
- ☐ Insulin or other diabetes drug
- ☐ Antiarrhythmics
- ☐ Nitroglycerin
- ☐ Cortisone or other steroids
- ☐ Osteoporosis (bone density) medicine
- ☐ Other:_____
  _____

Women:

- ☐ May be pregnant
  Expected delivery date: _____
- ☐ Taking hormones or contraceptives

Name of your physician:_____

Do you have any disease, condition, or problem not listed above?_____

DENTAL HEALTH HISTORY

1. Who was your previous dentist?_____
2. When was your last visit with a dentist or hygienist?_____
3. Why did you leave your previous dentist?_____
4. How many times per day do you brush? _____Floss?_____
5. Are there any teeth that are bothering you right now? _____
6. Are you happy with your teeth/smile?_____
7. Are you happy with the color of your teeth ?_____
8. Are you interested in dental services beyond cleaning and checking for cavities such as: tooth whitening, straightening your teeth, or replacing missing teeth?

   _____

APPOINTMENTS & CANCELLATIONS

When we book your appointment, we are reserving a room and time for your particular needs. We ask that if you must cancel, please give us *at least 24 hours notice*. This courtesy makes it possible to give your reserved room to another patient. Repeated cancellations or missed appointments will result in loss of future appointment privileges.

INSURANCE CONSENT

I certify that I (or my dependent) have insurance coverage and assign directly to Creekside Family Dental all insurance benefits otherwise payable to me for services rendered. ***I understand that I am financially responsible for all charges whether or not paid by insurance and that all insurance information provided by Creekside Family Dental is only an estimate of coverage***. I understand that Creekside Family Dental is not legally required to provide me with any of my insurance information but they are doing so as a courtesy to me. I hereby authorize the release of all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Date:_____

TREATMENT CONSENT

I consent to the diagnostic procedures and treatment by the dentist and dental hygienist necessary for proper dental care.

Patient Signature:_____

CREEKSIDE FAMILY DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

Please Print Name_____

Signature_____

Date_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices Acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

Employee Signature_____

NOTICE OF PRIVACY PRACTICES for CREEKSIDE FAMILY DENTAL

Revision Date: November 15, 2014

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

If you have any questions about this notice, please contact our Privacy Officer at (614) 487-0965.

WHO WILL FOLLOW THIS NOTICE: This notice describes our practice and that of (1) any healthcare professional authorized to enter information into your medical record that we maintain at this office; and (2) all employees, staff, and other healthcare personnel.

YOUR MEDICAL INFORMATION: We create a record of the care and services you receive at this office. We need this record to provide you with quality service and to comply with certain legal requirements. This notice applies to all of the records about you maintained by this office. Other physicians or health care providers that you use may have different policies or notices regarding the use and disclosure of your medical information. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to (1) make sure that medical information that identifies you is kept private; (2) give you this notice of our legal duties and privacy practices with respect to medical information about you; and (3) follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose medical information. “Use” is what we do with your information in this office. “Disclose” means sharing your information with others outside this office. All of the ways we are permitted to use and disclose information will fall within one of the categories.

▪ For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, office staff or other personnel who are involved in your care.

▪ For Payment. We may use and disclose medical information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party.

▪ For Health Care Operations. We may use and disclose medical information about you as reasonably necessary. These uses and disclosures are necessary to run the office and make sure that all of our patients receive quality care.

▪ To the Department of Health and Human Services (HHS). We must disclose your medical information when requested by HHS when it is undertaking a compliance investigation, review, or enforcement action.

▪ To You. We must disclose your medical information to you when you request it in writing, as described below. We may disclose your medical information to you in other situations.

▪ Opportunity to Agree or Object. We may disclose your medical information in front of others with your informal permission when you are present. If you are not present or otherwise unable to give permission, we may disclose your medical information to others if, in a healthcare provider’s professional judgment, disclosure is determined to be in your best interest. This includes telling family or friends involved in your care about your current medical condition. This also allows us to leave appointment reminders and messages with limited information on your voicemail and answering machine.

▪ Incidental Use. Although we try to limit communications of your medical information to the minimum necessary, we can disclose information that is incidental to an otherwise permissible use.

▪ Valid Authorization. We may disclose your medical information pursuant to your written authorization. For authorization to be valid, you must sign a form containing certain statements.

▪ Public Interest and Benefit Activities. We may disclose medical information about you for 12 national priority purposes, including when required by law, such as statute or court order; for public health activities, such as providing dental records to a school with a parent's permission; to government agencies regarding victims of abuse; to health oversight agencies to carry out legally authorized audits and investigations; pursuant to court orders and subpoenas that meet certain requirements; to law enforcement as described below; to a coroner or medical examiner; as necessary to facilitate organ or tissue donation and transplantation; for research purposes under certain circumstances; to prevent a serious threat to your health and safety or the health and safety of the public or another person; for certain essential government functions; and for workers' compensation or similar programs.

▪ Law Enforcement. We may disclose your Health Information if asked to do so by a law enforcement official (1) in response to a court order, subpoena, warrant, summons, or similar process; (2) about a death we believe may be the result of criminal conduct; (3) about criminal conduct at the office; or (4) in emergency circumstances, in order to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

▪ Limited Data Set. In certain situations we may disclose your medical information within a limited data set for research, healthcare operations, and public health purposes. A limited data set is medical information about you from which certain identifying information about you, your relatives, household members, and employers has been removed.

DISCLOSURES THAT REQUIRE AUTHORIZATION FROM YOU.

▪ Psychotherapy Notes, Marketing, and Sales of Protected Health Information. Most uses and disclosures of psychotherapy notes, protected health information for marketing purposes, and that constitute a sale of protected health information require authorization.

▪ Other. Other uses and disclosures not described in this notice will be made only with your authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU. You have the following rights regarding medical information we maintain about you:

▪ Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes prescriptions and billing records. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. We will select a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

▪ Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for this office.

To request an amendment, complete and submit an AMENDMENT REQUEST form to the Privacy Officer.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the medical information kept by or for the office; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is accurate and complete.

▪ Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

▪ Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request unless (1) the disclosure is for the purposes of carrying out payment or healthcare operations, and (2) the protected health information pertains to an item or service which you, or another person other than your health insurance, have paid for in full. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit the REQUEST FOR LIMITATION AND RESTRICTION OF PROTECTED HEALTH INFORMATION to the Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.

▪ Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

To request confidential communications, you may complete and submit the PATIENT'S REQUEST TO LIMIT CONFIDENTIAL COMMUNICATIONS to the Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.

▪ Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the Privacy Officer.

▪ Right to Receive Notice of Breach. You will receive notification of breaches of your unsecured protected health information unless we determine there is a low probability your PHI was compromised.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office. The summary will contain, in the top right-hand corner the effective date. You are entitled to a copy of the current notice in effect.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with the office, contact the Privacy Officer. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.