PATIENT REGISTRATION

Patient Information

First Name: ______________________ Last Name: ______________________

Preferred Name (If different than above): ______________________

Address: ______________________

City: ______________ State / Zip Code: _______ / ___________

Birth Date: _____/_____/_____ Social Security Number: ______________ Sex: ☐ Male ☐ Female

Cell Phone: (_____) ______________ Home Phone: (_____) ______________
(Text messages will be sent to confirm appointments- opt out options are available)

Email: ______________________ Work Phone: (_____) ______________
(E-mail messages will be sent to confirm appointments and/or office promotions- opt out options are available) Ext: _______

Preferred Pharmacy: ______________________

Emergency Contact: ______________ Relationship: ______________ Phone: (_____) ______________

Patient History

Last Dental Visit: ______________ Previous Dentist: ______________

How did you hear about our office? If you were referred by one of our patients, please write their name so we can thank them. ______________

____

Responsible Party (If patient is under 18 years old)

First Name: ______________________ Last Name: ______________________

Address: ______________________

City: ______________ State / Zip Code: _______ / ___________

Cell Phone: ______________ Home Phone: ______________ Work Phone: ______________

Birth Date: _____/_____/_____ Social Security Number: ______________ Ext: _______

PATIENT DISCLOSURE INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The individual's health information will be made available to referred specialists for the individual's advised treatment.

I allow you to give my clinical information to and answer questions from (*check all that apply*):

PLEASE LIST NAME AND PHONE NUMBER

☐ Spouse: ______________________
☐ Parent(s): ______________________
☐ Other (specify): ______________________
☐ None

______________________ ____/____/____ ______________________
Patient (or Guardian) Signature Date Print Name

Understanding Your Dental Benefits

Dental benefits have become an integral part of health care planning for many families. As the number of patients covered by dental plans has increased, certain assumptions have become evident. I would like to make the principles of my practice, as well as the types of service and care I provide my patients, very clear:

- Our fees are based on the overhead involved in the practice, the treatment plan selected, and the time it takes to provide you with the necessary dental care.
- The type of treatment you need and receive is based on my professional judgment and not on whether you are covered by a dental benefits plan. I am more than happy to discuss a treatment plan's advantages and disadvantages with you in order to accommodate you, not an insurance company, in the health care decision-making process.
- If treatment is recommended, our office will complete and present a treatment plan to you showing what treatment is recommended, the order in which the treatment is recommended to be rendered, the fees our office charges for the services needed, and an estimation of what your dental plan may cover. **This is only an estimation of your dental benefits.**
- The amount estimated to be your "out of pocket" on the treatment plan will be **due when services are rendered.**
- As a courtesy to you, our office will complete the dental claim form and send it to your insurance company.
- Your dental plan holds the right to deny or pay a different fee amount for services rendered. This may result in a further payment due to our office. **This balance is YOUR responsibility.**
- Pre-authorizations can be sent for the insurance company to review. However, please remember that the financial obligation for dental treatment is yours.

No question is too small for you to ask, whether it is about your treatment, benefit plan, or statement. Stop in or call us at (937) 738-7610 any time you have a question. We are here to help you and provide you with the best dental care possible!

Initial ____ **I have read and understand the above information. I have been given a chance to ask any questions regarding my individual insurance policy.**

Initial ____ **By signing below I agree that any balance due after insurance payment is my responsibility and not that of Cromwell Dental Care.**

24 Hour Cancellation Policy

We value your time and reserve appointment times based on the needs of each patient. By providing us with enough notice for rescheduling your appointment, we are able to open the reserved time up to other patients needing to be seen. This policy makes scheduling convenient for patients and allows us to begin and end your appointments on time.

We kindly ask that you provide a 24 hour notice if you must cancel an appointment. Without a 24 hour notice, there will be a **$25.00 charge** added to your account. This will not be covered by your insurance company.

Printed Name: ______________________________

Signature: ______________________________ Date: ______________

Cromwell Dental Care Inc

Medical History (2020)

Patient Name: Birth Date: Date Created:

Medical History

Who is your Primary Care Physician?	[ ]	Comment	[ ]
Date of Last Visit?	[ ]		
Have you had any serious medical issues/operations? Please Explain	○ Yes ○ No	If yes	[ ]
Have you ever taken medications containing bisphosphinates? (Ex: Actonel, Boniva, Fosamax)	○ Yes ○ No	If yes	[ ]
Do you use tobacco/vaping products? If so, what type, how much, and for how long?	○ Yes ○ No	If yes	[ ]

Mark if you have had any of the following. If marked please explain in the comment section below

☐ Angina/Chest Pains	☐ Cortisone Treatments	☐ Hepatitis B	☐ Shortness of Breath
☐ Arthritis	☐ Cough, Persistent	☐ Hepatitis C	☐ Skin Rash
☐ Artificial Heart Valve	☐ Diabetes	☐ High Blood Pressure	☐ Stroke
☐ Artificial Joint	☐ Epilepsy/Sieazures	☐ HIV/Aids	☐ Swelling of Fee/Ankles
☐ Asthma	☐ Fainting	☐ Jaw Pain	☐ Thyroid Problems
☐ Back/Neck Proplems	☐ Glaucoma	☐ Kidney Disease	☐ Tonsillitis
☐ Blood Diseases	☐ Headaches	☐ Liver Disease	☐ Tuberculosis, Currently
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ Ulcer
☐ Chemical Dependency	☐ Heart Conditions, Other	☐ Radiation Treatment	☐ Venereal Disease
☐ Chemotherapy	☐ Hemophilia	☐ Respiratory Disease	☐ Other

Comments

[ ]

Please List all medications that you are currently taking (including OTC medications) -- If you have a Medication List we will scan this into your chart.

[ ]

If Applicable, mark all that apply

☐ Currently Pregnant - If Yes, expected due date? ☐ Nursing ☐ Taking oral contraceptives

Allergies

☐ Aspirin	☐ Penicillin	☐ Sulfa Drugs	☐ Codeine
☐ Latex	☐ Local Anesthetics	☐ Other	☐ None

Please explain type of reaction [ ] Comment [ ]

See Reverse Side

Dental History

Reason fortoday's visit		Comment	
Previous Dentist		Comment	
Date of last dental exam			
Date of last dental X-rays			

Mark if you have had any of the following

- ☐ Bad Breath
- ☐ Loose Teeth
- ☐ Clicking/Popping Jaw
- ☐ Cold Sensitivity
- ☐ Bleeding Gums
- ☐ Periodontal Treatment
- ☐ Grinding/Clenching Teeth
- ☐ Hot Sensitivity
- ☐ Food Collection Between Teeth
- ☐ Missing Teeth
- ☐ Sores/Growths inyour mouth
- ☐ Sensitivity when biting

How would you grade your current dental health?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

How would you grade your smile?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Are you interested in getting more information on any of the following?

- ☐ Whitening
- ☐ Straightening your smile
- ☐ Cosemetic Dentistry
- ☐ Sleep Apnea
- ☐ Implants
- ☐ Athletic Mouthguards
- ☐ Wisdom Teeth Removal

How often do you floss? (Mark the one that describes your habits the best)

- ☐ Every Day of the Week
- ☐ Few times a Week
- ☐ Every other Week
- ☐ Never
- ☐ Other:

How often do you brush? (Mark the one that describes your habits the best)

- ☐ Twice Daily
- ☐ Once Daily
- ☐ Occasionally
- ☐ Never
- ☐ Other:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my resposibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:__________

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 08/22/2011, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and provide the new Notice at our practice location, and we will distribute it upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.

Your Authorization: In addition to our use of your health information for the following purposes, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Uses and Disclosures of Health Information:

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

To You or Your Personal Representative: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to your personal representative, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your absence or incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient under certain circumstances.

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.
Electronic Notice: You may receive a paper copy of this notice upon request.
Questions and Complaints
If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.
Contact Officer: Dr. Justin Cromwell
Telephone: (937) 738-7610 Fax: (937) 738-7614 E-mail: info@cromwelldentalcare.com
Address: 415 Coleman's Crossing Blvd. Marysville, OH 43040

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I acknowledge that I have read a copy of the Notice of Privacy Practices from Cromwell Dental Care. I also acknowledge that I was given the option to receive a copy of the Notice of Privacy Practices for my own personal records.

Patient Signature________________________________

OR

Signature of Legal Guardian________________________