The Dental Group AT POLARIS

Full Name _____ Today's Date _____

Mr. Mrs. Ms. Rev. Dr.

I prefer to be addressed as _____ Birthdate _____

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

Home Address _____ Home Phone _____

Work Address _____ Work Phone _____

City _____ State ____ Zip _____ Cell Phone _____

E-mail address _____

Preferred contact ❑E-mail ❑Home Phone ❑Work Phone ❑Cell Phone Best time to call _____

Employer _____ Occupation _____ SS#_____

Dental Insurance ❑Yes ❑No If yes, Insurance Co Group #_____

Insurance Address Policy Holder ID# _____

Policy Holder Name Policy Holder DOB _____

Financially Responsible Party ❑Self ❑Spouse ❑Parent/Guardian

Spouse / Partner _____ Phone _____

Additional Emergency contact _____ Phone _____

Last dental visit _____ with Dr. _____ City _____

Why have you made this appointment _____

PLEASE SELECT ONE BOX ON EACH LINE

❑My mouth is very comfortable ❑My mouth is moderately comfortable ❑My mouth is uncomfortable

❑My smile is excellent ❑I would like to change my smile ❑I am unconcerned about my smile

❑I will do whatever I must to keep my teeth ❑I want to keep my teeth but only within a certain budget of time and money

❑I've done the dentistry recommended to me ❑I've NOT done dentistry recommended to me ❑Never been recommended

MY DENTAL HEALTH IS ❑Excellent ❑Good ❑Fair ❑Poor

Physician _____ Phone _____ City _____

How would you assess your general health ❑Good ❑Fair ❑Poor Last physical _____

Have you been hospitalized in the last 3 years? ❑Yes ❑No Reason _____

List medications you take - please include prescription, supplements and over-the-counter

_____

_____

Allergies: Penicillin ____ Latex ____ Antibiotic ____ Other: ____

Do you currently or have a history of grinding/clenching your teeth? ❑Yes ❑No Wear an appliance? ❑Yes ❑No

Did you have braces? ❑Yes ❑No Do you feel you need to straighten your teeth? ❑Yes ❑No

Do you consider yourself under an abnormally high amount of stress? ❑Yes ❑No

Do you sleep well? ❑No ❑Yes Do you snore? ❑No ❑Yes History of sleep disorders? ❑No ❑Yes

Have you ever smoked or chewed tobacco? ❑No ❑ I Quit When? _____ ❑Yes - Still do How much? _____

Do you exercise regularly? ❑No ❑Yes If YES what do you enjoy doing _____

Do you now have or have you ever had the following?

❑YES ❑NO Severe or Frequent Headaches	❑YES ❑NO Mitral Valve Prolapse	❑YES ❑NO HIV / Aids
❑YES ❑NO Glaucoma	❑YES ❑NO High Blood Pressure	❑YES ❑NO Cold Sores/Fever Blisters
❑YES ❑NO Heart Attack	❑YES ❑NO Dementia/Alzheimers	❑YES ❑NO Tuberculosis
❑YES ❑NO Heart Murmur	❑YES ❑NO Psychiatric Problems	❑YES ❑NO Venereal Disease
❑YES ❑NO Abnormal Bleeding	❑YES ❑NO Drug / Alcohol Dependence	❑YES ❑NO Ulcers
❑YES ❑NO Hepatitis	❑YES ❑NO Epilepsy/Siezure	❑YES ❑NO Asthma
❑YES ❑NO Anemia	❑YES ❑NO Sinus Trouble	❑YES ❑NO Artificial Joint
❑YES ❑NO Chemotherapy	❑YES ❑NO Artificial Valve	❑YES ❑NO Arthritis
❑YES ❑NO Radiation Treatment	❑YES ❑NO Diabetes	

❑YES ❑NO Other _____

WOMEN

Are you taking birth control pills?	❑No ❑Yes
Are you pregnant?	❑No ❑Yes - Due date _____
Are you currently nursing?	❑No ❑Yes

The information present on these pages is true to the best of my knowledge. I authorize the doctor to take X-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. Upon my verbal agreement following discussion of recommended treatment, I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

I have read the above: Signature _____ **Date** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I acknowledge that I have been provided the The Dental Group At Polaris ("dentist") Notice of Privacy Practices ("Notice"):

- It tells me how the dentist will use my health information for the purposes of my treatment, payment for my treatment, and the dentist's dental care operations.

- The Notice also explains in more detail how the dentist may use and share my health information for other than treatment, payment, and dental care operations.

- The dentist will also use and share my health information as required/permitted by law.

Patient's Complete Legal Name: _____
(please print patient or legally authorized representative)

Relationship of Legally Authorized Representative to Patient: _____

Patient's SSN: _____

Patient's DOB: _____

Signature:_____

Date:_____

For Office Use Only

We attempted to obtain writing acknowledgment of receipt of our Notice of Privacy Practices and acknowledgment could not be obtained because:

__ Individual refused to sign

__ Communication barriers prohibit obtaining acknowledgement

__ An emergency situation prevented us from obtaining acknowledgement

__ Other (please specify) _____

Medical Information Release Form
(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____
[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

Consent for Use and Disclosure of Health Information

Purpose: In cases where The Dental Group At Polaris has directed not to rely on Acknowledgements as a basis to use or disclose health information, this form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy Practices.

The Dental Group at Polaris **9391 S Old State Rd** **Lewis Center, OH 43035**

SECTION A: PATIENT GIVING CONSENT

Name:

Address:

Telephone: E-mail:

Patient Number: Social Security Number:

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Mike Lofreso

Telephone: 614-888-3692

Address: 9391 S Old State Rd Lewis Center, Oh 43035

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protective health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name: _____ Relationship to patient: _____

Revocation of Consent

I revoke my Consent for your use and disclosure of my protective health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my consent before you received this Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____ Date: _____

You are entitled to a copy of this consent after you sign it. Include completed Consent in the patient's chart.

The Dental Group AT POLARIS

Insurance:

We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. We will prepare and submit forms and reports to assist you in obtaining maximum benefits available. However, the treatment recommendations or fees are not affected by the presence or absence of insurance benefits. Your dental benefits are a contract between you, your employer, and the insurance company.

Collections:

Payment for services rendered is due the day the services are performed. In the event that your balance becomes more than 90 days overdue, your account may be turned over to an outside collection agency. The responsible party agrees to pay interest, collection, and any legal expenses related to the collection of fees owed.

I agree to assume full financial responsibility for all services and treatment that is provided.

Signature _____ **Date**_____

The Dental Group AT POLARIS

PATIENT APPOINTMENT AGREEMENT

We make every effort to value your time and schedule your appointment time just for you.

We truly appreciate your courtesy of giving us 48 hours notice if you have a conflict with your appointment and need to schedule a different day or time. We are committed to your oral health and keeping your scheduled appointments allows us to be partners in your dental care.

- I acknowledge my appointment date/time is a reservation.
- I acknowledge I am required to provide 48 business hours to make any changes to my appointment.
- I acknowledge 8:00 am, 2:00 pm, and 3:00 pm appointments are considered VIP appointments, and if I miss an appointment without providing 48 hours' notice, I may not be able to schedule another VIP appointment.
- I acknowledge after 2 appointments in which I do not provide 48 hours' notice, I will be charged a $75 per hour fee and may be required to leave a 25% deposit in order to schedule my next appointment.
- I acknowledge after 3 appointments in which I do not provide 48 hours' notice, I will not be able to pre-appoint and may have to provide my full co-pay before being scheduled.

_____

Patient Signature

_____

Date