West Jefferson Dental

41 E Main St, West Jefferson, OH 43162 614-379-2868 www.WestJeffDental.com

Patient Information

Please save this form on computer first and fill it out using ADOBE.
Email the completed form to WestJeffDental@gmail.com

Date_____ Name _____ Sex M___ F___
Last, First, MI

Address_____City_____State_____Zip_____

SSN_____ Birthdate _____Email_____

Patient Employer_____Occupation_____

Employer Address_____Employer Phone_____

Please tell us how you heard about West Jefferson Dental:
Mailer___ Newspaper___ Internet___ Referred By_____ Other_____

Phone Numbers

Home_____ Cell Phone_____Work _____

Appointment Reminder Preference: Cell Phone___ Text___ Home Phone___ Work Phone___ Email___

Emergency Contact Name_____Relationship_____Phone_____

Insurance Information

Do you have Dental Insurance? Yes___No___ Do you have secondary Dental Insurance? Yes___ No___

Primary Insurance		Secondary Insurance	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber	Self__Spouse__ Child__ Other__	Relationship to Subscriber	Self__Spouse__Child__ Other__
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	
***Please present Insurance Card to the receptionist to be photocopied ***			

Medical History

West Jefferson Dental takes your oral health very seriously, but before we start your treatment, we need some brief information on your medical history. Your medical history may affect dental treatment. **All information is confidential.**

Have you been under the care of a Medical Doctor during the past two years? Yes☐ No☐

If yes, for what? _____

Physician's Name_____Last visit to Physician_____

Are you currently taking any medications, drugs or pills? Yes☐ No☐

If yes, please list name and dosage: _____

_____

_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing biphosphotanes?
Yes☐ No☐ If yes, for how long?_____

Are you allergic to any of the following? Aspirin☐ Penicillin☐ Codeine☐ Local Anesthetics☐
Acrylic☐ Metal☐ Latex☐ Sulfa drugs☐ Other (If yes, please explain)_____

Do you have a history of? (Check box if Yes)											
Rheumatic Fever	☐		Asthma	☐		Thyroid Disease	☐		Alcoholism	☐	
Heart Murmur	☐		Allergies or Hives	☐		Epilepsy or Seizures	☐		Psychiatric Treatment	☐	
Mitral Valve Prolapse	☐		Anemia	☐		Fainting or Dizzy Spells	☐		Mouth sores/growths	☐	
Diabetes	☐		Aspirin/Anticoagulant Therapy	☐		Ulcers or Stomach Problems	☐		Teeth Grinding/Clenching	☐	
Pace Maker/Heart Surgery	☐		Venereal Disease	☐		Arthritis	☐		Pain in your jaw (TMJ)	☐	
High Blood Pressure	☐		HIV Positive/AIDS	☐		Latex Allergy	☐		Any type of implant	☐	
Low Blood Pressure	☐		Blood Transfusion	☐		Sinus Problems	☐		Any type of transplant	☐	
Heart Problem ( )	☐		Excessive Bleeding	☐		Cancer (Type:)	☐		Any Artificial Hip, Knee or other Joint	☐	
Stroke	☐		Hepatitis (Type:)	☐		Chemotherapy	☐		Other Disease or Illness:		
Lung Disease	☐		Liver Disease	☐		Radiation Treatment	☐				
Breathing Problems	☐		Kidney Disease	☐		Use of Tobacco Products	☐				
Tuberculosis (TB)	☐		Dialysis	☐		Drug Addiction	☐				

Dental History

What is the purpose of your visit today? _____

Are you currently in pain? Yes☐ No☐ Do you require antibiotics before dental treatment? Yes☐ No☐

Have you experienced problems associated with any previous dental work? Yes☐ No☐

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes☐ No☐

Your current dental health is: Good☐ Fair☐ Poor☐

Do you floss daily? Yes☐ No☐ Brush daily? Yes☐ No☐

Type of bristles on your toothbrush? Hard☐ Medium☐ Soft☐

How long do you use a toothbrush before replacing it? _____

Do you use anything in addition to your brush and floss? Yes☐ No☐ If yes, what? _____

Would you like fresher breath? Yes☐ No☐ Whiter Teeth? Yes☐ No☐

Do your gums ever bleed? Yes☐ No☐

Have you ever had periodontal disease? Yes☐ No☐

Do you have mobility in your teeth? Yes☐ No☐

Are your teeth sensitive to heat, cold or anything else? Yes☐ No☐

Do you still have wisdom teeth? Yes☐ No☐

Previous/Present Dentist_____ Last Visit Date_____

Are you happy with the way your smile looks? Yes☐ No☐

If not, what would you change? _____

Women

Are you pregnant or planning pregnancy? Yes☐ No☐ Are you a nursing mother? Yes☐ No☐

If yes, due date_____ Are you taking birth control pills? Yes☐ No☐

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to West Jefferson Dental 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 the payments of benefits. I authorize the use of this signature on all insurance submissions. I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge.

Patient's Signature_____ Date_____

Dr's Signature/Medical History Review_____ Date_____

HIPAA POLICY

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of this might include coordinating medication with your medical doctor, implant services, lab services etc.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this might be filing a claim with your insurance company.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to aggress to a requested restriction. If we do agree to a restriction, we must abide by it unless you aggress in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.

- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of May 1, 2005 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

The following patient hereby acknowledges the receipt of this HIPAA Policy.

Patient Name _____Relationship to Patient _____

Signature: _____Date _____

For more information about HIPAA or to file a complaint, please contact:

US Dept of Health & Human Services Office of Civil Rights
200 Independence Avenue, SW
Washington, D.C. 20201
202-619-0257
Toll Free: 1-877-696-6775

Or feel free to contact us if you have any questions or for additional information.

Please email completed form to WestJeffDental@gmail.com