Family Dentistry

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Cell Phone: _____ **Home Phone:** _____**Work Phone:** _____

Email Address:_____

Date of Birth: _____ **Age:** _____ **Occupation:** _____

Social Security Number: _____ **Marital Status:** _____

Responsible Party *(if other than self)*: _____ **Relationship:** _____

Responsible Party Address: _____

Responsible Party Phone: _____

How did you hear about AP Family Dental? _____

Are you interested in Financing options? _____

INSURANCE INFORMATION

Name of Insurance Carrier: _____ **Group Number:** _____

Name of Insured *(if other than self)*: _____

Social Security Number of Insured *(if other than self)*: _____

Address of Insured *(if other than self)*: _____

Name of Insured Employer: _____

EMERGENCY CONTACT INFORMATION

Name of Contact: _____ **Phone Number:** _____

Relationship to Patient: _____

Authorization:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any of my health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental insurance carrier or payer of my dental benefits ***may pay less*** than the actual bill for services. I understand I am financially responsible for payment in full of all accounts. By signing this statement, I am agreeing to responsibility of services not paid in full or part by my dental care payer.

I attest to the accuracy of the information on this page.

Patient Signature X_____

DENTAL HISTORY (New Patients Only)

Reason for Today's Visit: _____

Date of Last Dental Visit: _____ **Date of Last Dental X-Rays:** _____

Former Dentist: _____

PLEASE CHECK IF YOU HAVE/HAD:

YES	NO	
❑	❑	Bad breath
❑	❑	Blisters on lip or mouth
❑	❑	Burning sensation on tongue
❑	❑	Chew on one side of the mouth
❑	❑	Cigarette, pipe or cigar smoking
❑	❑	Dry mouth
❑	❑	Food collection between teeth
❑	❑	Clench or grind teeth
❑	❑	Growth or sore spots in your mouth
❑	❑	Gums swollen, tender or bleeding
❑	❑	Head, neck, jaw pain or ache
❑	❑	Lip or cheek biting
❑	❑	Loose teeth or broken fillings
❑	❑	Mouth breathing
❑	❑	Orthodontic treatment
❑	❑	Periodontal treatment
❑	❑	Sensitivity to pressure or irritants (hot, cold, sweets)
❑	❑	**An allergic reaction to Novocain or other local anesthetics**

If YES, please specify: _____

❑ ❑ Any other issues or concerns

If YES, please specify: _____

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MEDICAL HISTORY

Physician's name: _____ **Date of Last Visit:** _____

Physician's address: _____

Have you had any serious illnesses or operations or been hospitalized? YES NO

If YES, please explain: _____

Have you ever had a blood transfusion? YES NO

If YES, please give approximate date: _____

Have you ever had to premedicate (antibiotics) prior to dental treatment? YES NO

If YES, please give the reason (e.g. joint replacement, artificial heart valve, infective endocarditis, etc.): _____

Do you take any blood thinners? (e.g. eliquis, warfarin/coumadin, pradaxa, xarelto, etc.) YES NO

If YES, please list which ones: _____

Have you ever been prescribed a bisphosphonate? (e.g. fosamax/alendronate, actonel, boniva, reclast, etc.) YES NO

If YES, please list which ones: _____

Have you ever been prescribed a steroid or an immunosuppressant? (e.g. cortisone, methotrexate, arava/leflunomide, etc.) YES NO

If YES, please list which ones: _____

Are you allergic to any medications? (e.g. amoxicillin, penicillin, sulfa, codeine, etc.) YES NO

If YES, please list which ones: _____

For Women

Are you pregnant? YES NO **If YES, Due Date:** _____ **Nursing?** YES NO **Taking birth control pills?** YES NO

PLEASE CHECK IF YOU HAVE/HAD:

YES	NO		YES	NO		YES	NO	
❑	❑	Allergies, hay fever, sinusitis	❑	❑	Artificial heart valve	❑	❑	Shortness of breath
❑	❑	Anemia	❑	❑	Heart problems			
❑	❑	Arthritis, Rheumatism	❑	❑	Heart attack	YES	NO	
❑	❑	Asthma	❑	❑	Hepatitis (Type _____)	❑	❑	Sinus trouble
❑	❑	Prolonged bleeding	❑	❑	Herpes/Venereal Disease	❑	❑	Sickle cell anemia
❑	❑	Blood/clotting disorders	❑	❑	High blood pressure	❑	❑	Skin rash
❑	❑	Cancer (Type_____)	❑	❑	HIV/AIDS	❑	❑	Slow healing wounds
❑	❑	Chemotherapy	❑	❑	Autoimmune disorder (_____)	❑	❑	Stroke
❑	❑	Radiation treatment				❑	❑	Swelling of feet or ankles
❑	❑	Chemical dependency	❑	❑	Jaundice	❑	❑	Thyroid problems
❑	❑	Circulatory problem	❑	❑	Kidney disease	❑	❑	Tonsillitis
❑	❑	Cough (persistent, bloody)	❑	❑	Liver disease	❑	❑	Tuberculosis
❑	❑	Diabetes (HbA1C: _____)	❑	❑	Low blood pressure	❑	❑	Tumor/growth on head or neck
❑	❑	Emphysema/COPD	❑	❑	Osteoporosis	❑	❑	Gastrointestinal ulcer
❑	❑	Epilepsy	❑	❑	Pacemaker/defibrillator	❑	❑	Weight loss, unexplained
❑	❑	Fainting	❑	❑	Respiratory disease	❑	❑	Do you wear contact lenses?
❑	❑	Glaucoma	❑	❑	Rheumatic fever	❑	❑	Do you consume alcoholic beverages?
❑	❑	Headaches	❑	❑	Scarlet fever	❑	❑	Are you currently under physician's care?
			❑	❑	Psychiatric treatment	❑	❑	Are allergic/sensitive to latex?
			❑	❑	Joint replacement			

*List any medications you are currently taking: _____

I have read and answered the above questions to the best of my knowledge.

Patient or Guardian (Print Name): _____ **Signature:** _____ **Date:** _____

Doctor Signature: _____ **Date:** _____

Family Dentistry

FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- All patients must complete our "Patient Information Form" prior to being seen by the dental professional
- Full payment is due at the time of service
- We accept CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT
- This practice provides insurance company billing as a courtesy to our patients. The patient portion of a dental service(s) is estimated and due at the time of service.

Adult Patients

- Adult patients are responsible for payment in full at the time of service.

Minors Accompanied by an Adult

- The adult accompanying a minor, his/her parents, or guardians are responsible for payment in full at the time of service

Unaccompanied Minors

- The parents or guardians are responsible for payment in full at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized.

Insurance

- This practice provides insurance company billing as a courtesy to our patients. The patient portion of a particular dental service(s) is estimated and due at the time of the service. This amount may be subject to adjustment, when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for dental services which can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of the dental services that exceed the plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by the staff regarding his/her remaining benefit in any such benefit period. The claims we submit to insurance companies indicate that you have assigned those benefits to us. However, if you are reimbursed by the insurance company, you then become responsible for the total account balance and payment would be expected immediately.
- If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available.
- You, as a patient, are always responsible for any charges that are not covered by your insurance.

NSF Fee

- All payment returned due to non-sufficient funds will be subject to a NSF fee of $25.00

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party (Print Name): _____

Responsible Party (Signature): _____

Date: _____

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SECTION A: PATIENT GIVING CONSENT

Last Name:_____ First Name:_____

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 the 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 requesting from the practice.

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.

SECTION C: SIGNATURE

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

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

NON-DISCRIMINATION POLICY

AP Family Dentistry and its affiliates comply with applicable federal civil rights laws and do not discriminate based on race, color, national origin, age, disability, or sex.

If requested, AP Family Dentistry and affiliates provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

If you need these services, contact the office manager at the practice location.

If you believe that AP Family Dentistry and its affiliates have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Kam Abed- Compliance Coordinator
9203 Mentor Ave,
Mentor, OH 44060
apfamily@apfamilydentistry.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Aziza Abed, Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington,
D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

ADA DENTAL PATIENT RIGHTS AND RESPONSIBILITIES STATEMENT

Family Dentistry

Your dentist is the best source of information about your dental health and wants you to feel comfortable about your dental care. Maintaining healthy teeth and gums means more than just brushing and flossing every day and visiting your dentist regularly. As an informed dental patient, it also means knowing what you can expect from your dentist and dental care team and understanding your role and responsibilities in support of their efforts to provide you with quality oral health care.

The rights and responsibilities listed below do not establish legal entitlements or new standards of care but are simply intended to guide you through the development of a successful and collaborative dentist-patient relationship.

PATIENT RIGHTS

1. *You have a right to* choose your own dentist and schedule an appointment in a timely manner.
2. *You have a right to* know the education and training of your dentist and the dental care team.
3. *You have a right to* arrange to see the dentist every time you receive dental treatment, subject to any state law exceptions.
4. *You have a right to* adequate time to ask questions and receive answers regarding your dental condition and treatment plan for your care.
5. *You have the right* to know what the dental team feels is the optimal treatment plan as well as the right to ask for alternative treatment options.
6. *You have a right to* an explanation of the purpose, probable (*short and long term*) results, alternatives and risks involved before consenting to a proposed treatment plan.
7. *You have a right* to be informed of continuing heath care needs.
8. *You have a right to* know in advance the expected cost of treatment.
9. *You have a right to* accept, defer or decline any part of your treatment recommendations.
10. *You have a right to* reasonable arrangements for dental care and emergency treatment.
11. *You have a right to* receive considerate, respectful and confidential treatment by your dentist and dental team.
12. *You have a right to* expect the dental team members to use appropriate infection and sterilization controls.
13. *You have a right to* inquire about the availability of processes to mediate disputes about your treatment.
14. You have the right to receive access to treatment and accommodations that are available regardless of race, sex, age, creed, sexual orientation, national origin, religion, handicap, or marital status

PATIENT RESPONSIBILITIES

1. *You have the responsibility to* provide, to the best of your ability, accurate, honest and complete information about your medical history and current health status.

2. *You have the responsibility* to report changes in your medical status and provide feedback about your needs and expectations.

3. *You have the responsibility to* participate in your health care decisions and ask questions if you are uncertain about your dental treatment or plan.

4. *You have the responsibility to* inquire about your treatment options and acknowledge the benefits and limitations of any treatment that you choose.

5. *You have the responsibility for* consequences resulting from declining treatment or from not following the agreed upon treatment plan.

6. *You have the responsibility to* keep your scheduled appointments.

7. *You have the responsibility to* be available for treatment upon reasonable notice.

8. *You have the responsibility to* adhere to regular home oral health care recommendations.

9. *You have the responsibility to* assure that your financial obligations for health

Areas within the practice may be limited to some requests for accommodations specifically where facility must maintain a sterile environment.