COLUMBUS GROVE FAMILY DENTISTRY
QUALITY CARE FOR ALL AGES

Earl J Recker, DDS - Shana L Schnipke, DDS
109 N High St - Columbus Grove, OH 45830
419-659-6000 Main - 419-659-6004 Fax
www.myfamilydentist.biz

NEW PATIENT FORM INSTRUCTIONS

Welcome to our office. We are glad that you have choose us to take care of your dental health needs. A brief description of the necessary forms, and instruction on their completion follows:

1. **Patient Registration**
   - General Information Form – eg. Name, Address, Insurance Information, ER Contact, Etc
     - ✓Please complete this page, one for each patient and bring it to the appointment.

2. **Medical History**
   - This Form Provides us with Information About Your Health & Dental Needs – eg. Diagnosed Conditions, Allergies, Dental Concerns and Habits, Etc
     - ✓Please complete this page, one for each patient and bring it to the appointment.

3. **Notice of Privacy Practices**
   - This Document Describes How the Practice Protects Information about You
     - ✓Please review this information, print it and keep it at home.

4. **Privacy and Communications Notice**
   - This Form Acknowledges that you Received a Copy of our Privacy Practices, Provides Permission for Us to Contact You through various Means, and States with Whom We May Share Information
     - ✓Please complete this page, one for each patient and bring it to the appointment.

5. **Consent to Treat & Release of Information**
   - This Form Gives us Your Consent to Provide Dental Treatment, and to Share Your Information with Providers who may Become Involved in Your Treatment – eg. Orthodontists, Etc
     - ✓Please complete this page, one for each patient and bring it to the appointment.

If you have any questions while completing our forms, please call us at 419-659-6000. Also, thank you for taking the time to complete them prior to presenting for your appointment. We are looking forward to seeing you soon!

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PATIENT REGISTRATION

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

Nick/Preferred Name (If Any):_____ Address (St/PO):_____

City: _____State/Zip Code:_____ Email Address:_____

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

Sex: ____ Male ____Female Marital Status: ____ Married ____ Single ____ Divorced ____ Widowed
Birth Date: _____ Age: _____ Social Security#: _____ Drivers License#:_____
Employment Status: ____NA ____Full Time ____Part Time ____Retired

Responsible Party Information (If Someone Other than Patient)
First Name:_____ Last:_____ Middle:_____

Nick/Preferred Name (If Any):_____ Address (St/PO):_____

City: _____State/Zip Code:_____ Email Address:_____

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

Sex: ____ Male ____Female Marital Status: ____ Married ____ Single ____ Divorced ____ Widowed
Birth Date: _____ Age: _____ Social Security#: _____ Drivers License#:_____
Employment Status: ____NA ____Full Time ____Part Time ____Retired

Primary Insurance Information:
Name of Insured: _____ Relationship to Patient: ____ Self ____ Spouse ____Parent
Insured Social Security#: _____ Insured Date of Birth: _____
Employer: _____ Ins Company: _____
Address: _____ Address:_____
Address 2:_____ Address 2:_____
City, State, Zip: _____ City, State, Zip: _____
Group #: _____ ID #_____

Secondary Insurance Information:
Name of Insured: _____ Relationship to Patient: ____ Self ____ Spouse ____Parent
Insured Social Security#: _____ Insured Date of Birth: _____
Employer: _____ Ins Company: _____
Address: _____ Address:_____
Address 2:_____ Address 2:_____
City, State, Zip: _____ City, State, Zip: _____
Group #: _____ ID #_____

In Case of Emergency, Contact: (Please List an Individual who does not Live in Your Household):
Name/Relationship: _____Phone: _____Hm _____Cell

Whom May We Thank for Referring You?: _____

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MEDICAL HISTORY

Dentists are oral health experts. They strive to keep your entire mouth (your teeth and their supportive structures) healthy and disease free. Your mouth is a part of your body, tied to all your other systems. Any health problems that you have, and any medications that you take, are all interrelated. For this reason, we require that you complete the following questionnaire.

Patient's Name:_____ **Date:**_____

Medical Doctor's Name/Address:_____

Are you under a Physician's Care Now? ☐-No ☐-Yes, explain:_____

Have you ever been hospitalized or had a major operation? ☐-No ☐-Yes, explain:_____

Have you ever had a serious head or neck injury? ☐-No ☐-Yes, explain:_____

Are you taking any medications, pills or drugs? ☐-No ☐-Yes, explain:_____

Are you on a special diet? ☐-No ☐-Yes, explain:_____

Do you use tobacco? ☐-No ☐-Yes, explain:_____

Do you use controlled substances? ☐-No Yes, explain:_____

Women Are you: ☐-Pregnant/Trying to get Pregnant? ☐-Nursing? ☐-Taking Oral Contraceptives?

Are you allergic to any of the following?

☐-Antibiotics Sulfa Drugs/Penicillin/Etc) ☐-Food ☐-Latex ☐-Local Anesthetics ☐-Metals ☐-Pain Killers ☐-Other

List Specifics/Explain Checked Boxes:_____

Do you have, or have you ever had, any of the following:

☐-AIDS/HIV Positive	☐-Chest Pains	☐-Frequent Headaches	☐-Irregular Heartbeat	☐-Scarlet Fever
☐-Alzheimer's Disease	☐-Cold Scores/Fever Blisters	☐-Genital Herpes	☐-Kidney Problems	☐-Shingles
☐-Anaphylaxis	☐-Congenital Heart Disorder	☐-Glaucoma	☐-Leukemia	☐-Sickle Cell Disease
☐-Anemia	☐-Convulsions	☐-Hay Fever	☐-Liver Disease	☐-Sinus Trouble
☐-Angina	☐-Cortisone Medicine	☐-Heart Attack/Failure	☐-Low Blood Pressure	☐-Spina Bifida
☐-Arthritis/Gout	☐-Diabetes	☐-Heart Murmur	☐-Lung Disease	☐-Stomach/Intestinal Disease
☐-Artificial Heart Value	☐-Drug Addiction	☐-Heart Pace Maker	☐-Mitral Valve Prolapse	☐-Stroke
☐-Artificial Join	☐-Easily Winded	☐-Heart Trouble/Disease	☐-Pain in Jaw Joints	☐-Swelling of Limbs
☐-Asthma	☐-Emphysema	☐-Hemophilia	☐-Parathyroid Disease	☐-Thyroid Disease
☐-Blood Disease	☐-Epilepsy or Seizures	☐-Hepatitis A	☐-Psychiatric Care	☐-Tonsillitis
☐-Blood Transfusion	☐-Excessive Bleeding	☐-Hepatitis B or C	☐-Radiation Treatments	☐-Tuberculosis
☐-Breathing Problem	☐-Excessive Thirst	☐-Herpes	☐-Recent Weight Loss	☐-Tumors or Growths
☐-Bruise Easily	☐-Fainting Spells/Dizziness	☐-High Blood Pressure	☐-Renal Dialysis	☐-Ulcers
☐-Cancer	☐-Frequent Cough	☐-Hives or Rash	☐-Rheumatic Fever	☐-Venereal Disease
☐-Chemotherapy	☐-Frequent Diarrhea	☐-Hypoglycemia	☐-Rheumatism	☐-Yellow Jaundice

Have you ever had any serious illness not listed above? ☐-No ☐-Yes, explain:_____

Dental History and Symptoms

Reason for today's visit:_____

_____

Former Dentist Name & Address:

_____

_____

Date of Last Visit:_____

Date of Last Dental X-Ray:_____

Check the Appropriate Box:

Bad Breath ☐-Yes ☐-No
Bleeding Gums ☐-Yes ☐-No
Blisters on Lips/Mouth ☐-Yes ☐-No
Mouth Pain ☐-Yes ☐-No

Burning Sensation on Tongue	☐-Yes ☐-No	Mouth Breathing	☐-Yes ☐-No
Chew on One Side of Mouth	☐-Yes ☐-No	Mouth Pain	☐-Yes ☐-No
Cigarette, Pipe or Cigar Smoking	☐-Yes ☐-No	Orthodontic Treatment	☐-Yes ☐-No
Clicking or Popping Jaw	☐-Yes ☐-No	Pain Around Ear	☐-Yes ☐-No
Dry Mouth	☐-Yes ☐-No	Periodontal/Gum Problems	☐-Yes ☐-No
Fingernail Biting	☐-Yes ☐-No	Sensitivity to Cold	☐-Yes ☐-No
Food Collection Between Teeth	☐-Yes ☐-No	Sensitivity to Heat	☐-Yes ☐-No
Foreign Objects	☐-Yes ☐-No	Sensitivity to Sweets	☐-Yes ☐-No
Grinding Teeth	☐-Yes ☐-No	Sensitivity when Biting	☐-Yes ☐-No
Gums Swollen or Tender	☐-Yes ☐-No	Sores or Growths in Mouth	☐-Yes ☐-No
Jaw Pain or Tiredness	☐-Yes ☐-No	**How Often do You:**	
Lip or Check Biting	☐-Yes ☐-No	**Brush?**_____	
Loose Teeth or Broken Fillings	☐-Yes ☐-No	**Floss?**_____	

Signature of Patient, Parent or Guardian:_____ **Date:**_____

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NOTICE OF PRIVACY PRACTICES

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. IT HAS BEEN USED BY THIS OFFICE SINCE 04/14/2003, AND REMAINS IN EFFECT UNTIL WE REPLACE IT.

1) OUR PLEDGE REGARDING DENTAL INFORMATION

The privacy of your dental information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our dental office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share dental information about you. We also describe your rights and certain duties we have regarding the use and disclosure of dental information. Throughout this notice we refer to your medical information as dental information.

2) OUR LEGAL DUTY

The Law Requires Us to:

1. Keep your dental information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your dental information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all dental information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3) USE AND DISCLOSURE OF YOUR DENTAL INFORMATION

The following section describes different ways that we use and disclose dental information. For each kind of use or disclosure, we will explain what we mean and give an example. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose dental information. *We will not use or disclose your dental information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.*

For Treatment: We may use dental information about you to provide you with dental treatment or services. We may disclose dental information about you to doctors, nurses, technicians, or other people who are taking care of you. We may also share dental information about you to your other health care providers to assist them in treating you.

For Payment: We may use and disclose your dental information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your dental information.

For Healthcare Operations: We may use and disclose your dental information for our healthcare operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certifications, licenses and credentials we need to serve you.

Additional Uses and Disclosures: In addition to using and disclosing your dental information for treatment, payment, and healthcare operations, we may use and disclose information for the following purposes:

Notification: We may use and disclose dental information to notify or help notify: a family member, your personal representative or another person responsible for your care. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, dental supplies, x-ray or other dental information for you.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of dental information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the dental information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use dental information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose dental information in response to a court order or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoenas, we may share your dental information with law enforcement officials. We may share limited information with a law enforcement official concerning the information of a suspect, fugitive, material witness, crime victim or missing person. We may share the dental information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your dental information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your dental information to persons subject to jurisdiction of the Food and Drug Administration for the purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose dental information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your dental information if it is necessary to prevent a serious threat to our health or safety or the health or safety of others. We may share dental information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose dental information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose dental information to an agency providing health oversight for oversight activities authorized by law, including audits, civil administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose dental information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose dental information for purposes of sending you appointment reminders, such as postcards, phone generated reminders, emails and/or text messages.

Alternative and Additional Dental Services: We may use and disclose dental information to furnish you with information about health related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4) YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your dental information. You may request that we provide copies in a format other than photocopies. We will use the format that you request, unless it is not practical for us to do so. You must make the request in writing. You may get the form to request access by using the contact information listed at the bottom of this notice. You may also request access by sending a letter to the listed contact person. If copies are requested, we will charge you the current going rate for each page, and postage if you want the copies mailed to you. For more information about this fee structure, you may make an inquiry to the contact person.
2. Receive a list of all the times we or our business associates shared your dental information for the purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your dental information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your dental information by different means or to different locations. This request must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your dental information. We may deny your request if we did not create the information you want changed, or for certain other reasons. If we deny our request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and with to receive a paper copy, you have the right to do so by making a request in writing to the contact person listed at the end of this notice.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may do so to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

Columbus Grove Family Dentistry
109 North High Street
Columbus Grove, Ohio 45830
Attn: Brenda Recker, Office Manager

You may also submit a complaint to the U.S. Department of Health and Human Services. We will provide you with their address as needed, and will not retaliate in any way if you choose to file a complaint.

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Acknowledgement of Receipt of Notice of Privacy Practices and Communications Rights

Patient's Name:_____

I have received a copy of Columbus Grove Family Dentistry's Notice of Privacy Policy.

Please note:

It is the policy of this office to confirm patient appointments and leave voice messages and/or text messages at phone numbers provided by our patients/guardians.

It is the policy of this office to leave phone messages and/or text messages requesting our patients to call us concerning health care issues.

To that extent:

I authorize my healthcare/dental provider and/or any entity authorized by my healthcare/dental provider, including those using automated dialing systems, automated messages, email, text messaging, or other electronic communication to contact me for any reason by using any telephone number, cellular or otherwise, email address, and/or mailing address provided.

I UNDERSTAND THAT BY FILLING IN THE INFORMATION BELOW I AUTHORIZE YOUR OFFICE TO CONTACT ME BY ANY AND ALL MEANS I HAVE LISTED.

Home Phone #: _____

Cell Phone #: _____

Check here if you **DO NOT** want to receive text messages. _____

Email Address: _____

The aforementioned communications may be shared with:

NAME:	**RELATIONSHIP:**
_____	_____
_____	_____
_____	_____

Authorization:

Patient's/Guardian's Printed Name:_____

Signature:_____Date:_____

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Consent to Treat & Release of Information

Patient's Name:_____

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

I consent to the dentist's use and disclosure of my records, or of my child's records, to carry out treatment, to obtain payment, and for those activities and health care operations that are related to the treatment or payment.

My consent for treatment and disclosure of records shall be effective until I revoke it in writing.

I understand and agree that I am responsible for payment of the bill.

Authorization:
Print Name & Relationship to Patient:_____
Signature:_____Date:_____