

***Anderson Family Dentist***

**PATIENT REGISTRATION**

FIRST NAME _____	LAST NAME _____	MIDDLE INITIAL _____
DATE OF BIRTH _____	SOCIAL SECURITY # _____	DRIVERS LICENSE # _____
SINGLE _____	MARRIED _____	WIDOWED _____
SEPERATED _____	DIVORCED _____	

**PATIENT CONTACT INFORMATION**

HOME PHONE _____	CELL PHONE _____	EMAIL ADDRESS _____
HOME ADDRESS _____	CITY _____	STATE _____ ZIP _____
HOW DO YOU PREFER TO BE CONTACTED? EMAIL _____ TEXT _____ CALL _____ (CELL OR HOME#)		

**RESPONSIBLE PARTY(IF OTHER THAN PATIENT)**

FIRST NAME _____	LAST NAME _____	MIDDLE INITIAL _____
DATE OF BIRTH _____	SOCIAL SECURITY # _____	DRIVERS LICENSE # _____
HOME ADDRESS _____	CITY _____	STATE _____ ZIP _____

**WHOM SHOULD WE THANK FOR REFERRING YOU?** \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY**

FIRST NAME _____	LAST NAME _____	MIDDLE INITIAL _____
(AS SHOWN ON INSURNACE CARD)		
INSURANCE COMPANY NAME _____		
SUBSCRIBER ID _____	GROUP # _____	

**SECONDARY**

FIRST NAME _____	LAST NAME _____	MIDDLE INITIAL _____
(AS SHOWN ON INSURANCE CARD)		
INSURNACE COMPANY NAME _____		
SUBSCRIBER ID _____	GROUP # _____	

**EMERGANCY CONTACT** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**RELATION TO PATIENT** \_\_\_\_\_

# Dental History

Patient Name \_\_\_\_\_

*Welcome! So we can provide you with the best possible care,  
please complete this dental history form.  
All information is completely confidential.*

What is the reason for your visit today? \_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_ Last Dental Cleaning \_\_\_\_\_ Last Full Mouth Xrays \_\_\_\_\_

Previous Dentist's Name \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_

Telephone Number \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Do you use any other products? (Listerine, Waterflosser, etc.) \_\_\_\_\_

## Are any teeth sensitive to:

Hot or cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Have you noticed mouth odors/bad taste? Yes No

Any other oral lesions? Yes No

## Have you ever had:

Orthodontic treatment? Yes No

Oral Surgery? Yes No

Periodontal Treatment/Surgery? Yes No

Bite plate or night guard? Yes No

Retainers? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease? Yes No

Or tooth loss? Yes No

## Have you ever experienced:

Clicking or popping of the jaw? Yes No

Pain (ear, jaw joint, side of face)? Yes No

Difficulty opening or closing your mouth? Yes No

Headaches, neck aches, shoulder aches? Yes No

Do you clench or grind your teeth while awake or asleep? Yes No

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If yes, please describe \_\_\_\_\_

If there is anything else you would like us to know about receiving dental treatment? \_\_\_\_\_

\_\_\_\_\_

## Eaglesoft Medical History

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	<input type="radio"/> Yes <input type="radio"/> No	If yes	
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes	
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use controlled substances?	<input type="radio"/> Yes <input type="radio"/> No	If yes	

Women: Are you...

☐ Pregnant/Trying to get pregnant?☐ Nursing?☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin☐ Penicillin☐ Codeine☐ Acrylic☐ Metal☐ Latex☐ Sulfa Drugs☐ Local Anesthetics

Other?

☐

If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
						Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes

Comments:

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 responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: \_\_\_\_\_

## Financial Responsibility

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Patient Name:

Birth Date:

I verify all information given is correct and give my consent for initial treatment and examination.

I understand my insurance is an agreement between my insurance company and me. I understand I am responsible for the balance of my account regardless of my insurance.

I authorize the release of any dental information necessary to process any insurance claim and authorize insurance payment of dental benefits directly to Dr. Bill Anderson for all services.

I understand payments for co-pays and or deductibles are due at time services are provided.

I understand that I may incur a monthly finance charge for balances over 30 days. I understand balances over 90 days will be subject to additional collection fees, including attorney fees and interest charges until balance is paid in full.

I understand that any personal check returned unpaid or with non-sufficient funds(NSF) will incur a \$50.00 NSF check fee.

### Signature

Date of signing

Name

Relationship to Patient;

Self

Spouse

Child

Other

# CONFIRMATION OF NOTICE OF PRIVACY PRACTICES & CONSENT

Anderson family Dental

2133 Tiffin Avenue  
Findlay, Ohio 45840  
419-427-1500

Effective Date: 3-1-2022

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.

*We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the dental care we provide and may receive such records (medical and/or dental) from others. We use these records to provide or enable other health care providers to provide quality dental care, to obtain payment for services provided to you as allowed by your dental plan and to enable us to meet our professional and legal obligations to operate this dental practice properly. We are required by law to maintain the privacy of protected health information (PHI), to provide individuals with notice of our legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information.*

Our office must obtain your written consent before it can disclose information about you for payment purposes. For example, our office must obtain your written consent before it can disclose information to your dental insurer in order to be paid for services. Generally, you must also sign a written consent before the office can share information for treatment purposes or for health care operations.

Before our office can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing.

I, \_\_\_\_\_ have received a copy of the Notice of Privacy Practice, and it has been explained to me.

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Parent/Guardian Signature (if necessary) Date

Patient's Name if Signed by Parents/Guardian \_\_\_\_\_

# NOTICE OF PRIVACY PRACTICES

Anderson Family Dental

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## Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

### Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

### Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

### Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

### Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say “yes” unless a law requires us to share that information.

### Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

### Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

### File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

### In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

### In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

### In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

## Our Uses and Disclosures

**How do we typically use or share your health information?** We typically use or share your health information in the following ways.

### Treat you

- We can use your health information and share it with other professionals who are treating you.

### Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

### Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

**How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

### **Help with public health and safety issues**

- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

### **Do research**

- We can use or share your information for health research.

### **Comply with the law**

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

### **Address workers' compensation, law enforcement, and other government requests**

- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

### **Respond to lawsuits and legal actions**

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

## **Changes to the Terms of This Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.