

# Anderson Family Dentist

## PATIENT REGISTRATION

FIRST NAME _____	LAST NAME _____	MIDDLE INTIAL _____		
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 INTIAL _____	
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 # _____	

EMERGENCY 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

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease? Yes No

Or tooth loss? 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

## 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? \_\_\_\_\_

\_\_\_\_\_



# Financial Responsibility

---

Patient First Name

-

Patient Last 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 the 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 the balance is paid in full.

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

I understand appointments cancelled with less than a **24 hour notice** or missed appointments will incur a **\$50 cancellation fee**.

Signature (ESign)

Name

-

Date :

Relationship to Patient;

Self

Spouse

Child

Other

# CONFIRMATION OF NOTICE OF PRIVACY PRACTICES & CONSENT

Anderson Family Dental  
1301 E. Sandusky St.  
Findlay, OH 45840

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  
1301 E. Sandusky St.  
Findlay, OH 45840

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.

## 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.



# Medical History

Patient's First Name:

-

Patient's Last Name:

-

Birthdate:

-

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

Are you under a physician's care now?

-

If Yes:

-

Have you ever been hospitalized or had a major operation?

-

If Yes:

-

Have you ever had a serious head or neck injury?

-

If Yes:

-

Are you taking any medications, pills, or drugs?

-

If Yes:

-

Do you take, or have you taken, Phen-Fen or Redux?

-

If Yes:

-

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

-

If Yes:

-

Do you use tobacco ?

-

If Yes:

-

Are you on a special diet?

-

If Yes:

-

Do you use controlled substances?

-

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 Other, Please specify:

-

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

AIDS/HIV Positive

-

Alzheimer's Disease

-

Anaphylaxis

-

Anemia

-

Angina

-

Arthritis/Gout

-

Artificial Heart Valve

-

Artificial Joint

-

Asthma

-

Blood Disease

-

Blood Transfusion

-

Breathing Problem

-

Bruise Easily

-

Cancer

-

Chemotherapy

-

Chest Pains

-

Cold Sores/Fever Blisters

-

Congenital Heart Disorder

-

Convulsions	Cortisone Medicine	Diabetes
-	-	-
Drug Addiction	Easily Winded	Emphysema
-	-	-
Epilepsy or Seizures	Excessive Bleeding	Excessive Thirst
-	-	-
Fainting spells/Dizziness	Frequent Cough	Frequent Diarrhea
-	-	-
Frequent Headaches	Genital Herpes	Glaucoma
-	-	-
Hay Fever	Heart Attack/Failure	Heart Murmur
-	-	-
Heart Pacemaker	Heart Trouble/Disease	Hemophilia
-	-	-
Hepatitis A	Hepatitis B or C	Herpes
-	-	-
High Blood Pressure	High Cholesterol	Hives or Rash
-	-	-
Hypoglycemia	Irregular Heartbeat	Kidney Problems
-	-	-
Leukemia	Liver Disease	Low Blood Pressure
-	-	-
Lung Disease	Mitral Valve Prolapse	Osteoporosis
-	-	-
Pain in Jaw Joints	Parathyroid Disease	Psychiatric Care
-	-	-
Radiation Treatments	Recent Weight Loss	Renal Dialysis
-	-	-
Rheumatic Fever	Rheumatism	Scarlet Fever
-	-	-
Shingles	Sickle Cell Disease	Sinus Trouble
-	-	-
Spina Bifida	Stomach/Intestinal Disease	Stroke
-	-	-
Swelling of Limbs	Thyroid Disease	Tonsillitis
-	-	-
Tuberculosis	Tumors or Growths	Ulcers
-	-	-
Venereal Disease	Yellow Jaundice	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 the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Signature of Patient, Parent, or Guardian:

Signature: (ESign)

Date :



# Patient Authorization Form

---

Many of our patients allow family members to call and request treatment information, procedures and financial information. Under the requirements of H.I.P.P.A. we are not allowed to give this information to anyone without a patient's consent. If you wish to have your dental information, diagnostic test results and/or financial information released to family members, you must complete and sign this form. If signing this form as P.O.A., please provide appropriate documentation.

## Authorization to Release Information to Family Members

Patient First Name

Patient Last Name

-

-

**I authorize Anderson Family Dentist to release my records and any information selected below to the following individuals:**

You have the right to revoke this consent in writing, except where we have already made disclosure on your prior consent.

### Release Information To:

-

### Relationship to Patient

-

### Release Information To:

-

### Relationship to Patient

-

## Authorizations: Please check all that apply

Checkboxes

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> I authorize you to speak with or leave a message with my spouse, family member, significant other, parents or children regarding appointments. | <input type="checkbox"/> I authorize you to speak with or leave a message with my spouse, family member, significant other, parents or children regarding my financial information. | <input type="checkbox"/> I authorize you to speak with or leave a message with my spouse, family member, significant other, parents or children regarding my dental treatment and/or diagnosis.. |
|---|---|--|

E-Signature (draw, upload or type) (ESign)

Date

Date :

-



# Emergency Contact

---

## In case of an Emergency, who can we contact for you?

First Name	Last Name	Phone Number
-	-	-
Relationship to Patient	Name of Primary Care Physician	Phone Number
-	-	-
Preferred Hospital	E-Signature (draw, upload or type) (ESign)	
-	Date :	