Welcome

Today's Date:_____

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name_____ Soc. Sec. #_____ Birth Date_____

Address_____ City_____ State_____ Zip _____

Sex ☐ M ☐ F Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Minor ☐

Hm Ph _____ Wk _____ Cell _____

Where is the best place to reach you? _____ Email Address_____

Patient Employed By_____ Occupation_____

Person to contact in case of emergency_____ Phone_____

May we ask how you found our office? _____

Responsible Party Information

Person Responsible For Account _____ Relation to Patient _____

Soc. Sec. #_____ Birth Date_____ Email Address _____

Address_____ City_____ State_____ Zip _____

Hm Ph _____ Wk _____ Cell _____ DL# _____

Where is the best place to reach you? _____ Is this person currently a patient in our office? Yes ☐ No ☐

Primary Dental Insurance

Subscriber Name_____ Phone #: _____

Relationship to Patient_____ DOB_____ Soc. Sec. # _____

Address_____ City_____ State_____ Zip _____

Person Responsible Employed By_____ Occupation_____

Insurance Company _____

Address_____ City_____ State_____ Zip_____

Phone #_____ Group # _____

Annual Maximum_____ Deductible _____ Used_____

Additional Dental Insurance

Does Patient Have Additional Coverage? Yes ☐ No ☐ If yes, please complete below.

Subscriber Name _____ Phone #:_____

Relationship to Patient_____ DOB_____ Soc. Sec. #_____

Address_____ City_____ State_____ Zip _____

Person Responsible Employed By_____ Occupation_____

Insurance Company _____

Address_____ City_____ State_____ Zip _____

Phone #_____ Group # _____

Annual Maximum_____ Deductible_____ Used_____

Over Please

Patient Dental History

Are you currently experiencing any dental discomfort? Yes ☐ No ☐

If so, please explain_____

Previous Dentist's Name_____ Phone #_____

Date of last dental care_____ Date of last x-rays _____

Please check (√) **Yes** or **No** if you have had problems with any of the following:

☐Y ☐N Bad breath
☐Y ☐N Bleeding gums
☐Y ☐N Clicking or popping jaw
☐Y ☐N Sensitivity to sweets
☐Y ☐N Wear partials or dentures
☐Y ☐N Frequent headaches
☐Y ☐N Grinding or clenching
☐Y ☐N Loose teeth or broken fillings
☐Y ☐N Sores or lumps in mouth
☐Y ☐N Bleeding during brushing/flossing
☐Y ☐N Periodontal treatment
☐Y ☐N Sensitivity to cold
☐Y ☐N Sensitivity to hot
☐Y ☐N Sensitivity when biting
☐Y ☐N Previous orthodontic treatment

Patient Medical History

Physician's name_____ Phone # _____

Date of last visit_____ Have you had any serious illnesses or operations? ☐Y ☐N

If yes, please describe _____

Are you currently under physician care? ☐Y ☐N If yes, please describe _____

Are you currently taking any medications? ☐Y ☐N If yes, please describe_____

Have you ever had a blood transfusion? ☐Y ☐N If yes, please give approx. dates_____

Have you ever taken Phen-Fen/ Redux? ☐Y ☐N

Women Only: Are you pregnant or trying to get pregnant? ☐Y ☐N Nursing? ☐Y ☐N Taking birth control pills? ☐Y ☐N

Are you allergic to any of the following? Yes ☐ No ☐ If yes, please mark accordingly.

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

☐ Other If yes, please explain: _____

Please check (√) **Yes** or **No** whether you have had any of the following:

☐Y ☐N Heart murmur
☐Y ☐N Mitral valve prolapse
☐Y ☐N Joint replacement
☐Y ☐N Rheumatic/Scarlet fever
☐Y ☐N AIDS/HIV Positive
☐Y ☐N Allergies/Hay fever
☐Y ☐N Anaphylaxis
☐Y ☐N Anemia
☐Y ☐N Angina
☐Y ☐N Arthritis/Rheumatism
☐Y ☐N Artificial heart valves
☐Y ☐N Asthma
☐Y ☐N Blood disease
☐Y ☐N Cancer
☐Y ☐N Chemical dependency
☐Y ☐N Chemotherapy
☐Y ☐N Diabetes
☐Y ☐N Emphysema
☐Y ☐N Epilepsy/Seizures
☐Y ☐N Fainting
☐Y ☐N Food allergies
☐Y ☐N Glaucoma
☐Y ☐N Headaches
☐Y ☐N Heart disease/problems
☐Y ☐N Hemophilia
☐Y ☐N Herpes/HPV
☐Y ☐N Hepatitis/Jaundice
☐Y ☐N High/Low blood pressure
☐Y ☐N Kidney disease
☐Y ☐N Leukemia
☐Y ☐N Liver disease
☐Y ☐N Pacemaker/Heart surgery
☐Y ☐N Psychiatric care
☐Y ☐N Recent weight gain/loss
☐Y ☐N Radiation treatment
☐Y ☐N Respiratory disease
☐Y ☐N Spina Bifida
☐Y ☐N STD
☐Y ☐N Stomach troubles/ulcers
☐Y ☐N Stroke
☐Y ☐N Swollen feet/ankles
☐Y ☐N Thyroid disease/problem
☐Y ☐N Tobacco habit
☐Y ☐N Tuberculosis

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature_____ Date_____

Doctor's Comments/Signature_____ Date_____

Laury DiMichaelangelo, Lisa Johnson & Mickey Harrison, Inc.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

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 our 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 contacting:

Contact Person: Pam DiMichaelangelo

Telephone: 614-267-5000 Fax: 614-267-0541

E-mail: nodg@sbcglobal.net

Address: 3974 Karl Road

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, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your 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 on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____