NEW PATIENT REGISTRATION FORM

Staff Initials	
Today's Date	

Please fill out this form as complete as possible. Missing information may cause a delay in receiving treatment and/or any applicable dental insurance benefits. Thank you and welcome to our office!

PATIENT INFORMATION

Patient's Name		Street Address	City, State, Zip
Home Phone #	Cell Phone #	Email	Social Security #
Date of Birth	☐ Male ☐ Female ☐ Non-Conforming	☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Domestic Partnership ☐ Minor	Appointment Reminder Preference ☐ Text ☐ Email ☐ Phone ☐ None
Employer & Occupation		Employer Address	Work Phone #
Spouse's Name		Employer	Cell Phone #
Emergency Contact		Relationship to Patient	Phone #

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ Internet Ad ☐ Postcard ☐ Office Sign ☐ Friend/Family: ____________________
(please let us know who referred you, so we can send them their free gift!)
☐ Facebook ☐ Phonebook ☐ Billboard
☐ Google ☐ Radio ☐ Angie's List ☐ Dr. Referral: ____________________
☐ Email ☐ Insurance ☐ Former Patient ☐ Other: ____________________

RESPONSIBLE PARTY (skip if same as above)

Name of Person Responsible for Account		Billing Address	City, State, Zip
Home Phone #	Cell Phone #	Email	Social Security #
Date of Birth	☐ Male ☐ Female ☐ Non-Conforming	Relationship to Patient	Are you currently a patient in our office? ☐ Yes ☐ No
Employer & Occupation		Employer Address	Work Phone #

DENTAL INSURANCE

Patient DOES NOT have:
☐ Primary or Secondary Dental Insurance
☐ Secondary Dental Insurance

*** PLEASE FILL OUT THIS SECTION COMPLETELY.**
Insurance companies will not share your benefit or coverage details unless Sunbury Plaza Dental provides the information below.

PRIMARY DENTAL INSURANCE			SECONDARY DENTAL INSURANCE		
Policy Holder's Name		Relationship to Patient	Policy Holder's Name		Relationship to Patient
Social Security #		Date of Birth	Social Security #		Date of Birth
Phone #	Work #	Employer	Phone #	Work #	Employer
Insurance Company		Insurance Phone #	Insurance Company		Insurance Phone #
Insurance ID#			Insurance ID#		

DENTAL HEALTH & HISTORY

What is the reason for your visit today? ______________________________

Previous Dentist: ____________________ Date of Last Visit: ____________ Date of Last Cleaning: ____________

Are you nervous about seeing a dentist? ☐ Yes ☐ No If 'yes', why? ______________________________

What are your dental priorities?
- ☐ Appearance
- ☐ Dental Health
- ☐ Pain Resolution/Comfort
- ☐ Financial Considerations
- ☐ Other: ____________

Please check all that apply:
- ☐ Clench/grind during day or night
- ☐ Gums bleed while flossing/brushing
- ☐ Sore/tender gums
- ☐ Had treatment for gum disease
- ☐ Jaw clicks/pops
- ☐ Facial or jaw surgery
- ☐ Avoid brushing areas due to pain
- ☐ Difficulty chewing
- ☐ Food gets trapped in teeth
- ☐ Dry mouth
- ☐ Sensitive gag reflex
- ☐ Use/d whitening products
- ☐ Use/d electric toothbrush
- ☐ Had orthodontic work
- ☐ Would like whiter teeth
- ☐ Would like straighter teeth
- ☐ Had a reaction to local anesthetic

MEDICAL HEALTH & HISTORY

I consider my overall health to be: ☐ Excellent ☐ Good ☐ Fair ☐ Poor	Physician's Name	Physician's Phone #	Date of Last Visit

I take an antibiotic pre-medication* for dental visits: ☐ Yes ☐ No If yes, please list medication:

**We are unable to prescribe/refill/fill pre-medications. It is the patient's responsibility to contact their primary care physician for this medication.*

Describe any current medical treatment, recent hospitalizations, major surgeries, and/or impeding surgeries:

Please mark YES or NO to ALL CONDITIONS LISTED (mark YES to any condition/s you currently have or have had in the past):

YES	NO	Condition
☐	☐	Abnormal BP
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Artificial Joints
☐	☐	Aspirin Therapy
☐	☐	Asthma
☐	☐	Bisphosphonates
☐	☐	Blood Disease
☐	☐	Blood Thinner
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Cold Sores
☐	☐	Diabetes
☐	☐	Dizziness or Fainting
☐	☐	Drug Addiction
☐	☐	Emotional Disorder
☐	☐	Epilepsy or Seizures
☐	☐	Excessive Bleeding
☐	☐	Excessive Urination
☐	☐	Excessive Thirst
☐	☐	Frequent Headaches
☐	☐	Glaucoma
☐	☐	Hay Fever or Sinus Issues
☐	☐	Head Injury
☐	☐	Hearing Loss
☐	☐	Heart Attack
☐	☐	Heart Disease
☐	☐	Heart Murmur or MVP
☐	☐	Hepatitis
☐	☐	Herpes/STDs
☐	☐	Hip/Knee Replacement
☐	☐	HIV or AIDS
☐	☐	Immune Disorder
☐	☐	Jaundice
☐	☐	Kidney Disease/ Dialysis
☐	☐	Leukemia
☐	☐	Liver Disease
☐	☐	Pacemaker
☐	☐	Radiation Therapy
☐	☐	Respiratory Problems
☐	☐	Rheumatic Fever
☐	☐	Stent
☐	☐	Stomach Problems
☐	☐	Stroke
☐	☐	Thyroid Disease
☐	☐	Tobacco Use
☐	☐	TB / Lung Disease
☐	☐	Tumor or Malignancy
☐	☐	Ulcers

Are you currently pregnant or nursing? ☐ Yes ☐ No

Please list any other medical issues not listed above: ______________________________

____

ALLERGIES

Please check all that apply:
- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Penicillin / Amoxicillin
- ☐ Codeine
- ☐ Local Anesthetics
- ☐ Latex, Metals, Plastics
- ☐ Acrylic
- ☐ Sulfa Drugs
- ☐ Erythromycin
- ☐ Other, please list: ____________

MEDICATIONS

Please list all medications you are currently taking: (please attach a list if you need additional space)

Medicine: ____________ Condition: ____________

Medicine: ____________ Condition: ____________

Medicine: ____________ Condition: ____________

Medicine: ____________ Condition: ____________

Medicine: ____________ Condition: ____________

Medicine: ____________ Condition: ____________

PATIENT / RESPONSIBLE PARTY CONSENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform Sunbury Plaza Dental of any changes to my personal information, insurance, and/or health. After explanation from the doctor, I authorize the performance of dental services and procedures that the doctor deems necessary in order to carry out treatment, as well as the administration of any anesthetics and x-rays.

______________________________ Signature

____________ Date

NOTICE OF PRIVACY PRACTICES

The privacy of your health information is important to us. This notice describes how your health information may be used, disclosed, and how you can access this information. Please review this notice carefully.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice, while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose you health information in connection with our healthcare operations, which include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Family and Friends: We must disclose your health information to you, as described in the Patient Rights sections of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or payment for your healthcare, but only if you agree in writing that we may do so.

Persons Involved in Care: Your health information may be disclosed to family members or any other person responsible for your care to notify them of your location, general condition, or death. If you are present, we will provide you with an opportunity to object to such uses or disclosures. In the event of incapacitation or emergency circumstances, we will disclose health information based on a determination using our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or another crime. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose protected health information to correctional institutions or law enforcement officials who have lawful custody of a patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, texts, emails, postcards, or letters). You may opt out of these messages by contacting our office.

(continued on next page)

YOUR PATIENT RIGHTS

Access: You have the right to review or get copies of your health information. Requests must be made in writing and mailed to our office; you may obtain a form to request access by using the contact information listed at the end of this Notice. We may charge a reasonable fee for expenses such as copies, postage, and staff time. We can also prepare a summary of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, etc. for the past 6 years. If you request this more than once in a 12-month period, we may charge a reasonable fee.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request, in writing, that we communicate with you about your health information through alternative means and/or locations. Your request must specify the alternative means or location, and provide a satisfactory explanation on how payments will be handled under said request.

Amendment: You have the right to request, in writing, that we amend your health information. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by email, you are entitled to receive a printed copy.

MORE INFORMATION

We support your right to health information privacy. If you want more information about our privacy practices or have questions or concerns, please contact us. You may also contact the U.S. Department of Health and Human Services.

Contact Officer: Lori Ferensen, Office Manager
Email: lorif@sunburyplazadental.com
Telephone: 614-891-6767
Address: 6025 S. Sunbury Rd. | Westerville, OH 43081
www.sunburyplazadental.com

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

You may refuse to sign this Acknowledgement

I have received a copy of Sunbury Plaza Dental's Notice of Privacy Practices.

Print Name: ______________________________

Signature: ______________________________ Date: ______________

In addition to myself, I authorize Sunbury Plaza Dental to disclose my protected health information to the following individual/organization for a period beginning on the date of this Acknowledgement and continuing indefinitely unless I direct otherwise in writing to Sunbury Plaza Dental.

Print Name: ______________________________

Relationship: ______________________________

Sunbury Plaza Dental

IMPORTANT PATIENT INFORMATION

MISSED / BROKEN APPOINTMENT POLICY

When patients choose an appointment time, that time is reserved specifically for them and their treatment needs. There are several ways missed appointments and last-minute cancellations can negatively affect patients and the office:

- Patients' treatment gets delayed, possibly leading to more dental issues that could require additional procedures and expense.
- Other patients needing treatment are unable to be seen during that time.
- Doctors, hygienists, and facilities aren't being utilized, adding to the overall cost of care.

To avoid "breaking" an appointment, we ask that patients notify our office at least 24-hours in advance and by noon on Thursdays for appointments the following Monday. Patients with numerous broken or missed appointments will be asked to schedule same-day appointments going forward.

PAYMENT AGREEMENT

Full payment of planned services is due before or at the time of service, unless prior arrangements have been made with one of our financial coordinators. Payment for minors' treatment is the responsibility of the parent or legal guardian. Payment options include: cash, check, money order, Care Credit, Visa, MasterCard, Discover, and AmEx.

Our office will send three statements for outstanding balances at 30, 60, and 90-days. If payment is not made within that time, the account will be subject to review by an outside collection agency. We reserve the right to add late fees to past due accounts. It is your responsibility to let us know if you have a change of mailing address or phone number.

DENTAL INSURANCE INFORMATION

Understanding your insurance coverage can be quite challenging, so our goal is to assist you with maximizing your benefits. Because we treat patients employed by many different companies, each with unique insurance coverage, **we encourage you to be aware of your policy exclusions, deductibles, and required co-payments prior to your appointments.** We are unable to accept state-funded insurance programs at this time, nor can we accept cash payments from those who carry such insurance plans.

OUR COURTESY SERVICE TO YOU INCLUDES:

1) Researching your dental insurance plan to advise you of available benefits. In order to do so, you **must** provide:
   a. an active dental insurance card and/or
   b. policy holder's name, date of birth, social security #, phone #, employer & phone #, insurance company & phone #, and insurance ID #
2) Filing your insurance within 48-hours of your visit and requesting payment to our office.
3) Following the American Dental Association (ADA) guidelines for coding and filing procedures.

POLICY HOLDER'S RESPONSIBILITIES:

1) Payment of fees not covered by your insurance plan.
2) Taking responsibility for payment if the insurance company does not pay our office within 60 days.
3) Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
4) Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called usual and customary rates), and exclude some procedures based on prior conditions or length of time on plan. All restrictions are based on the premium paid for insurance, not our fees or recommended treatment.
5) Keeping our office informed of any changes in your insurance coverage or employment.

I authorize Sunbury Plaza Dental to release information acquired in the course of my dental treatment to my dental insurance company (if insured). I understand that I'm responsible for any unpaid balance and agree to be fully responsible for the total cost of services rendered. I understand that fee estimates provided to me by Sunbury Plaza Dental, in regards to my insurance coverage, can vary from the amount actually reimbursed and that it is my responsibility to pay for any portion not covered by my insurance company. I understand that the final cost of treatment may vary from original estimates if said treatment needs to be altered and so long as I have agreed to the revised treatment plan.

______________________________ **Signature**

______________________________ **Date**