Dental Group West

5532 W. Central Avenue - Toledo, Ohio 43615 **419-539-2168**

Chart Number _____

_____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ____ _____ _____
First **Last** **MI** **Preferred** **Title**

Gender: Male ___, Female ___ **Family Status: Married ___, Single ___, Child ___, Other _____** **Birthdate:** _____

Last Dental Visit: _____ **Email Address:** _____ **Social Security #** _____

Phone: _____ _____ _____ _____
Mobile **Home** **Work / Ext** **Best time to call:**

Address: _____
Street **City** **State** **Zip Code**

Preferred Method of Contact: _____

Employer Name: _____

PRIMARY INSURANCE

Name of Insured: _____ _____ _____
First **Last** **MI**

Patient's relationship to insured:

Self _____, Spouse ____, Child _____, Other _____

Insurance Plan Name _____

Group # _____ **ID #** _____ **Company Phone #** _____

SECONDARY INSURANCE

Name of Insured: _____ _____ _____
First **Last** **MI**

Patient's relationship to insured:

Self _____, Spouse ____, Child _____, Other _____

Insurance Plan Name _____

Group # _____ **ID #** _____ **Company Phone #** _____

Medical Infomation

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ * Anesthetic Allergy
- ☐ AFib
- ☐ Artificial Joints
- ☐ Blood Disease
- ☐ Congenital heart Def
- ☐ Emphysema
- ☐ Fainting
- ☐ Head Injuries
- ☐ Heart Surgery
- ☐ HIV or AIDS
- ☐ Kidney Disease
- ☐ MitralValveProlapse
- ☐ Other
- ☐ Psychiatric Disorder
- ☐ Rheumatism
- ☐ Stomach Problems
- ☐ Ulcers
- ☐ *Codeine Allergy
- ☐ Allergies
- ☐ Artificial Valve
- ☐ Cancer/Tumors
- ☐ Diabetes
- ☐ Endocrine Problems
- ☐ Fever Blisters/Cold
- ☐ Heart Attack
- ☐ Hemophilia
- ☐ Hyper/Hypoglycemia
- ☐ Liver Disease
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Radiation
- ☐ Seizures
- ☐ Stroke
- ☐ Venereal Disease
- ☐ *Penicillin Allergy
- ☐ Anemia
- ☐ Asthma
- ☐ Canker Sores
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Intestinal Problems
- ☐ Low Blood Pressure
- ☐ Osteoarthritis
- ☐ Pen
- ☐ Respiratory Problems
- ☐ Shingles
- ☐ Thyroid Problems
- ☐ *Pre-med
- ☐ Arthritis
- ☐ Bleeding Problems
- ☐ Chemotherapy
- ☐ Drug Dependency
- ☐ Epstein Barr Virus
- ☐ Hay Fever
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Lung Disease
- ☐ Osteoporosis
- ☐ premed
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Tuberculosis

- ☐ Subject to frequent headaches or migraines
- ☐ FEMALE: Pregnant
- ☐ Tobacco/AlcohoUse
- ☐ Snoring/Sleeping Issues
- ☐ FEMALE: Taking birth control pills

Have you been outside of the country within the last 14 days? * ◯ Yes ◯ No

Have you had or tested positive for Covid-19? * ◯ Yes ◯ No

If any conditions or alerts selected above need further clarification, please describe below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

List all medications (prescription and non-prescription), including regular dosages of aspirin.

Please list all allergies to medications and or latex.

If there have been any medical changes since your last visit with us, please list below.

Please list other any other health conditions not listed above.

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.**

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. For treatment over $300 per appointment, we are happy to offer a 3% bookkeeping discount (5% for seniors) when full payment of the full fee is made the day of service. Excluded are patients with contracted insurance discounts.

Patients on a budget can make comfortable monthly payments, interest free, for up to 6 months, or for longer periods with interest, upon approval. We'd be happy to explain the programs available at this time.
Patients with dental insurance must pay the estimated insurance co-payment the day service is rendered if the practice receives your benefit check. If your insurance provider sends you a benefit check, the practice expects payment in full the day of service.

Please note: Dental Group West will be happy to help you submit your dental insurance; however, it is important to understand that some insurance companies notoriously delay payment of your benefit. In order to keep billing cost to a minimum, Dental Group West allows 6 weeks for your insurance carrier to submit payment. Beyond this time, you will be billed by the practice once, without interest, for the balance due on your account. This amount must then be paid in two weeks. (A 0.33% per month (4% per annum) late charge is assessed to the balance of your account for a late payment.) You may, at any time, roll your balance due into the "Easy Payment Plan" to avoid late charges - just ask your patient coordinator! If your insurance payment arrives late, we will issue a refund check to you promptly.
I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ * **By checking this box, I understand the above information and agree with its contents, and will serve as my electronic signature for the Administration Form.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ * **By checking this box, I understand the above information and agree with its contents, and will serve as my electronic signature for the Administration Form.**