

# PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.  
The information provided is important to your dental health.

Patient's name _____	Preferred name _____	Birth date _____
If minor, parents names _____	Home phone _____	Cell phone _____
Mailing address _____	City _____	State _____ Zip _____
Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Social Security # _____	
Employer _____	Occupation _____	Work phone _____
Spouse's name _____	Spouse's employer _____	<input type="checkbox"/> Unmarried
BILLING, CREDIT, AND INSURANCE INFORMATION: <input type="checkbox"/> Not covered by dental insurance		
Your Social Security number: _____	Dental Insurance Co. _____	Group number _____
Covered by spouse's insurance? <input type="checkbox"/> yes <input type="checkbox"/> no		
Spouse's dental insurance company _____	Group number _____	
Spouse's birthday _____	Social Security number _____	

## MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?  
(Please check any that apply)

- Cancer or tumor
- Heart ailment or angina
- Heart murmur, heart defect
- Mitral Valve Prolapse
- Rheumatic fever or rheumatic heart disease
- Artificial joint or valve
- High or low blood pressure
- Pacemaker
- Tuberculosis or other lung problems
- Kidney disease
- Hepatitis or other liver disease
- Alcoholism
- Blood transfusion
- Diabetes
- Neurologic condition
- Epilepsy, seizures, or fainting spells
- Emotional condition
- Arthritis
- Herpes or cold sores
- AIDS or HIV positive
- Migraine headaches or frequent headaches
- Anemia or blood disorders
- Abnormal bleeding after extractions, surgery, or trauma
- Hayfever or sinus trouble
- Allergies or hives
- Asthma

Do you smoke or use chewing tobacco?  yes  no

Are you allergic to, or have you reacted adversely to any of the following?

- Latex materials
- Penicillin or other antibiotics
- Local anesthetics ("Novocain")
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Other: \_\_\_\_\_

Are you taking any of the following?

- Aspirin
- Anticoagulants (blood thinners)
- Antibiotics or sulfa drugs
- High blood pressure medicine
- Antidepressants or tranquilizers
- Insulin, Orinase, or other diabetes drug
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine
- Other: \_\_\_\_\_

Women:

- May be pregnant  
Expected delivery date: \_\_\_\_\_
- Taking hormones or contraceptives

Name of your physician: \_\_\_\_\_

Do you have any disease, condition, or problem not listed above? \_\_\_\_\_

Please add anything else you would like us to know about: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ Phone # \_\_\_\_\_

Signature of patient (or parent) \_\_\_\_\_ Date \_\_\_\_\_

## PRACTICE FINANCIAL ARRANGEMENT FORM

We are committed to providing you with the best possible dental care and are pleased to discuss any and all of our professional fees at any time. Your clear understanding of our Financial Arrangement Form is very important to our professional dental relationship. If you have any questions or concerns, please ask one of our qualified team members.

We request that you settle your account by paying for treatment at the time service is rendered. For your convenience we accept Cash, Personal Checks, Visa, MasterCard, Discover and American Express.

**Insurance** – Your insurance benefits are determined by your employer, not your dentist. Insurance is not a guarantee of payment; they will not pay for all of your costs. Your insurance policy is a contract between you and your insurance company. Your insurance and personal payment portion is still your responsibility. As a courtesy we will file your insurance claim for you if you bring: 1) your dental insurance wallet card and 2) all required employer information. If our office is unable to verify your insurance information before treatment, you will be expected to pay for services in full on the day of your visit. If payment for previous services has not been paid in full within 45 days, either by you or your insurance company, **the remaining balance for treatment is considered due and collectible.**

**Financial Arrangements** – Financial arrangements must be determined before any treatment begins and will only be extended to patient(s) having major comprehensive dental treatment. Fees and time-frame will be discussed prior to beginning treatment. We have several options available which will be discussed when you meet with a treatment coordinator.

**New Patient/Urgency Appointments** – We will be happy to make an appointment for you to take care of your treatment needs. For these specific appointments, payment will be collected IN FULL at the time of service until you are established in our practice as a participating patient. Once established, regular payment policies will apply.

**Broken Appointments/Short Notice Cancellations** – A phone call will be extended to patients who do not show for their appointment. A missed appointment is an appointment that is either not shown up for or canceled in less than 24 hours. We understand things happen last minute sometimes and we allow our patient two broken appointments. However, after the 3<sup>rd</sup> broken appointment the patient will only be seen on an emergency basis for 6 months. Appointments are reserved exclusively for you. If canceled or broken, the time is taken away from other patients who are waiting to be placed in our schedule.

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Printed Name

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Signature

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Date



Upper Sandusky Dental  
Mitchell VanHoose DDS  
646 N Sandusky Ave  
Upper Sandusky, OH 43351

## PATIENT HIPAA CONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and an updated copy will be provided at you next visit. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

Signed this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.

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

Signature \_\_\_\_\_

Relationship to Patient \_\_\_\_\_