Amelia Dental Center

PO BOX 744 | 105 W MAIN ST - AMELIA, OH 45102-1701 (513)753-1077

WELCOME TO OUR PRACTICE

Today's Date: ____________________

Chart#: ________________
FOR OFFICE USE ONLY

Patient Name: ______________ Last ______________ First ____ MI ______________ Preferred Name

Title: ________ Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ____________ **SS#:** ___-__-____ **Prev. Visit:** ____________

Email Address: ______________________________ **Best time to call:** ______________

Phone: ________ Home ________ Mobile ________ Work ____ Ext ________ Fax ________ Other

Address: ______________________ Address 1 ______________________ Address 2

______________________ City ______ State _____-____ Zip Code

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: ______________________________ **Phone:** ______________

Employer Address: ______________________ Address 1 ______________________ Address 2

______________________ City ______ State _____-____ Zip Code

Whom may we thank for referring you to our practice?

____

In an emergency who should be notified? Please enter FULL NAME/ RELATIONSHIP TO PATIENT/ PHONE NUMBER:

____

____

Responsible Party Information:

This ONLY needs to be filled out if the insurance subscriber is NOT the patient, OR if you are the parent/guardian of the patient

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: ______________ Last ______________ First ____ MI ______________ Preferred Name

Title: ________ Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ____________ **SS#:** ___-__-____ **DL#:** ____________________

Email Address: ______________________________ **Best time to call:** ______________

Phone: ________ Home ________ Mobile ________ Work ____ Ext ________ Fax ________ Other

Address: ______________________ Address 1 ______________________ Address 2

______________________ City ______ State _____-____ Zip Code

PRIMARY DENTAL INSURANCE

Name of Insured: ______________________ ______________________ ____
Last First MI

Insured's Birth Date: __________ **ID #:** ______________ **Group #:** __________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Insured's Employer Name: ______________________________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________________________

Insurance Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Insurance Company Phone Number:

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

SECONDARY DENTAL INSURANCE

Name of Insured: ______________________ ______________________ ____
Last First MI

Insured's Birth Date: __________ **ID #:** ______________ **Group #:** __________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Insured's Employer Name: ______________________________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________________

Insurance Address: ______________________________ ______________________________

Address 1 Address 2

______________________________ ______ ______

City State Zip Code

Insurance Company Phone Number

____

____

Insurance Authorization

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist Name and Phone Number:

____

____

Date of most recent dental exam and dental x-rays:

____

____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

____

____

Is there anything about the appearance of your smile that you would like to change?

____

____

Check all that apply:

☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ You experience dry mouth
☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
☐ Food gets trapped between any teeth
☐ Have you ever whitened or bleached you teeth
☐ Have you experienced popping and/or clicking of your jaw joint
☐ You have difficulty chewing
☐ You clench or grind your teeth
☐ You wear or have worn a bite appliance
☐ Gums bleed when brushing or flossing
☐ Treated for gum disease or were told you have lost bone around your teeth
☐ Noticed an unpleasant taste or odor in your mouth
☐ Experienced gum recession
☐ Had any teeth become loose on their own (without injury)
☐ Experienced a burning sensation in your mouth
☐ You snore or wake up frequently during the night

OFFICE POLICY

FINANCIAL POLICY:
Basically, our policy is to deliver the most comprehensive dental care and as cost-effective as possible. We will strive to be as accurate as possible in our estimate of what your treatment will cost before we begin. Therefore, your co-payments and deductibles will be due at the time of service.
To assist you, we accept cash, checks, all major credit cards and CareCredit.
There will be times when the treatment is more extensive than originally estimated and if this occurs, Dr. Godfroy will inform you of the change as well as explain the need for it and your estimate will be adjusted accordingly.

INSURANCE
As a courtesy to our patients, we will be happy to file your insurance and accept assignment. However, to avoid misunderstanding, please read and understand the following:

1. It is your responsibly to be fully aware and knowledgeable about our insurance coverage and inform us of any changes.
2. We ask that you view your insurance realistically. It is an insurance plan that either you or your employer has chosen and some services may not be covered.
3. Any balance left unpaid by insurance is your responsibility. This balance is to be paid in full when you receive a statement from us.
4. When your treatment is for basic and/major services, a copayment or deductible will be due at the first visit.

APPOINTMENTS
We provide our patients with scheduled appointment times. By keeping your scheduled appointment, you allow us to make your visit with us comfortable and pleasant as well as be efficient with your time. Missed or changed appointments at the last minute, are then unavailable to other patients who need them. Therefore, we reserve the right to charge $50.00 for a broken appointment when a 48 hour notice is not given.

I have read and I understand the above OFFICE POLICY.

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

HIPAA

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature and date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

I understand that:
1) Protected health information may be disclosed or used for treatment, payment or healthcare operations.
2) The practice reserves the right to change the privacy policy as allowed by law.
3) The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
4) The patient has the right to revoke this consent in writing at ay time and all full disclosures will then cease.
5) The practice may condition receipt of treatment upon execution of this consent.

May we phone, email or send a text to you to confirm appointments: * ○ Yes ○ No

May we leave a message on your answering machine at home or on your cell phone? * ○ Yes ○ No

May we discuss your medical condition with any member of your family and/or friends? * ○ Yes ○ No

If YES, please name the person(s) allowed: *

____

____

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

IMPORTANT: IF YOU ARE FINISHED, PLEASE SCROLL DOWN AND CLICK ON THE SUBMIT BUTTON. THANK YOU.

Response Date: __________

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PATIENT MEDICAL HISTORY

Patient Name: ______________________ ______________________ ____ ______________________
Last First MI Preferred Name

YOUR PRIMARY CARE PHYSICIAN, ADDRESS AND PHONE NUMBER:

____

____

LIST OF MEDICATIONS:

____

____

____

____

____

____

____

IT IS VERY IMPORTANT FOR YOU TO LET US KNOW IF YOU CURRENTLY TAKE OR EVER START TO TAKE ANY OF THE FOLLOWING MEDICATIONS. PLEASE MARK ANY OF THE FOLLOWING TO INDICATE YES RESPONSE:

- ☐ ACTONEL (RISEDRONATE)
- ☐ ASPIRIN
- ☐ BLOOD THINNERS (ANTICOAGULANTS)
- ☐ DIDROCAL (ETIDRONATE)
- ☐ HEPARIN
- ☐ ZOMETA
- ☐ AREDIA (PAMIDRONATE)
- ☐ BISPHOSHONATE (ANY)
- ☐ COUMADIN (JANTOVEN)
- ☐ FOSAMAX (ALENDRONATE) (CHOLECALCIFEROL)
- ☐ PLAVIX

ARE YOU ALLERGIC TO:

- ☐ ASPIRIN
- ☐ CODEINE
- ☐ LATEX
- ☐ LOCAL ANESTHETICS
- ☐ METALS
- ☐ NITROUS OXIDE
- ☐ PENICILLIN
- ☐ SEDATIVES
- ☐ SULFA DRUGS

OTHER:

____

____

____

PLEASE MARK ANY OF THE FOLLOWING TO INDICATE YES IN RESPONSE TO THE QUESTION:

- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Are you currently taking any prescription or non-prescription medications?
- ☐ Do you use tobacco (smoking or chewing)?
- ☐ Do you use alcohol?
- ☐ Do you use recreational drugs?
- ☐ Do you have any joint replacements?
- ☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

IF ANY OF THE PREVIOUS QUESTIONS ARE MARKED, PLEASE EXPLAIN AND INDICATE HOW MUCH AND HOW FREQUENT:

____

____

____

____

PLEASE CHECK ALL THAT APPLY:

- ☐ ADD
- ☐ ADHD
- ☐ AIDS/HIV+
- ☐ ALLERGY PENICILLIN
- ☐ ALLERGY-CODEINE
- ☐ ALLERGY-ERYTHROMYCIN
- ☐ ALLERGY-LATEX
- ☐ ALLERGY-METALS
- ☐ ALLERGY-MORPHINE
- ☐ ALLERGY-MOTRIN
- ☐ ALLERGY-PREDNISONE
- ☐ ALLERGY-SULFA
- ☐ ANEMIA
- ☐ ANGINA
- ☐ ANXIETY
- ☐ ARTHRITIS
- ☐ ARTIFICIAL JOINT
- ☐ ASPIRIN
- ☐ ASTHMA
- ☐ BIRTH CONTROL
- ☐ BLOOD DISEASE
- ☐ BLOOD THINNER
- ☐ CANCER
- ☐ CARAPACE NUTS
- ☐ CEPHALEXIN
- ☐ CHEMOTHERAPY
- ☐ CHOLESTEROL
- ☐ CILANTRO
- ☐ COPD
- ☐ DEMENTIA
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ DIZZINESS
- ☐ EMPHYSEMA
- ☐ EPILEPSY
- ☐ FAINTING
- ☐ GLAUCOMA
- ☐ HAY FEVER
- ☐ HEAD INJURIES
- ☐ HEARING IMPAIRED
- ☐ HEART ATTACK
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ JAUNDICE
- ☐ KEFLEX
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ LOW BLOOD PRESSURE
- ☐ MENTAL DISORDERS
- ☐ MITRAL VALVE PRO
- ☐ MULTIPLE SCLEROSIS
- ☐ NERVOUS DISORDERS
- ☐ NITROUS OXIDE
- ☐ OTHER
- ☐ PACEMAKER
- ☐ PARKINSONS' DISEASE
- ☐ PREGNANCY
- ☐ PREMEDICATE
- ☐ QUINOLONES
- ☐ RADIATION TREATMENT
- ☐ RESPIRATORY PROBLEMS
- ☐ RHEUMATIC FEVER
- ☐ RHEUMATISM
- ☐ SEIZURES
- ☐ SINUS PROBLEMS
- ☐ STATINS
- ☐ STOMACH PROBLEMS
- ☐ STROKE
- ☐ THYROID PROBLEM
- ☐ TOBACCO USE
- ☐ TUBERCULOSIS
- ☐ TUMORS
- ☐ ULCERS
- ☐ VALVE REPLACEMENT
- ☐ VENEREAL DISEASE
- ☐ VICODIN ALLERGY
- ☐ VISUALLY IMPAIRED
- ☐ WHEEL CHAIR- YES
- ☐ ZITHROMAX

NOTES ON ABOVE:

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____

____

____

WOMEN ONLY: Are you..

☐ Pregnant or think you are? ☐ Nursing? ☐ Taking Birth Control pills?

If Yes, when is the due date? ________________________

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health or medications, I will inform the office at my next dental appointment without fail.**

AUTHORIZATION

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to be paid directly to the dentist or dental practice and to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian for PATIENT MEDICAL HISTORY:

Signature ______________________________ **Date** __________

Relationship to Patient:

____

____

IMPORTANT!!

IF YOU ARE FINISHED, PLEASE SCROLL DOWN AND CLICK ON THE SUBMIT BUTTON. THANK YOU.

Response Date: __________