McCOMB
FAMILY DENTAL

Name:_____
Last First MI

I prefer to be called:_____

Birthdate:___/___/_____ Age:____

Address:_____Apt# ____

_____
City State Zip

Email:_____

☐ Single ☐ Divorced ☐ Widowed
☐ Married ☐ Separated ☐ Partner

Home #:_____ Work #:_____

Cell #:_____

When is the best time to reach you?_____

Employer: _____

Occupation:_____

Today's Date:_____

☐ Male
☐ Female

Spouse Name:_____

Spouse Employer:_____

Contact number:_____

Referred By:_____

Previous Dentist: _____

Last Dental Visit:_____

Primary Care Physician: _____

EMERGENCY CONTACT:

Name:_____

Relation:_____ Phone:_____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Do you, or have you been told that you:

Hold your breath while sleeping? ☐ Yes ☐ No

Wake up gasping for breath? ☐ Yes ☐ No

Snore? ☐ Yes ☐ No

Do you smoke or use tobacco? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

Do you vape? ☐ Yes ☐ No

Are you currently in dental pain? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

If no, why?_____

For Women: *Are you using a prescribed method of birth control?* ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No *Week #:___* *Are you nursing?* ☐ Yes ☐ No

Everyone:

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other
Y	N	Dental Anesthetics	Y	N	Penicillin			

Please list any other drugs/ materials that you are allergic to:_____

_____

OVER

Have you ever had any of the following diseases or medical problems

Y	N	Abnormal Bleeding	Y	N	Hepatitis
Y	N	Alcohol/ Drug Abuse	Y	N	Herpes/ Fever Blisters
Y	N	Anemia/sickle cell	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	HIV/ AIDS
Y	N	Artificial Bones/ Joints/ Valves	Y	N	Hospitalized for Any Reason
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Blood Transfusion	Y	N	Liver Disease
Y	N	Cancer	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Lupus/Fibromyalgia
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Diabetes	Y	N	Osteoporosis/ Paget's Disease
Y	N	Difficulty Breathing	Y	N	Pacemaker
Y	N	Emphysema	Y	N	Psychiatric Treatment
Y	N	Epilepsy	Y	N	Radiation/chemotherapy
Y	N	Fainting Spells	Y	N	Seizures
Y	N	Frequent Headaches	Y	N	Shingles
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Stroke
Y	N	Heart Murmur	Y	N	Thyroid Problems
Y	N	Heart Surgery/Stents	Y	N	Tuberculosis (TB)
Y	N	Hemophilia	Y	N	Ulcers

Please list any serious medical condition(s) that you have ever had:

_____

_____

Please LIST all prescription, over-the-counter or supplemental drugs you are currently taking:

_____ _____

_____ _____

_____ _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I understand payment is due at time of service unless prior arrangements have been approved.

_____

Signature Date

Doctor Comments:_____

_____ **Initials:**_____ **Date:**_____

Initials:_____ Date:_____ Initials:_____ Date:_____ Initials:_____ Date:_____

Initials:_____ Date:_____ Initials:_____ Date:_____ Initials:_____ Date:_____

NOTICE OF PRIVACY PRACTICES
(Dental)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include the business aspects for running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request except to the extent that we have already take actions relying on your authorization.

You have the following rights with respect to you protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friend or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

The notice is effective as of April 12, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from the office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

McComb Family Dentistry
269 Park Drive South
P O Box 788
McComb OH 45858

For more information about HIPAA
Or to file a complaint:

The U.S. Department of Health & Human
Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

McCOMB
FAMILY DENTAL

McComb Family Dental
269 Park Drive South, McComb , OH 45858
PH: (419) 293-2335 - FAX: (419) 293-2512

HIPAA Communication Form

Patient Name:_____ Today's Date:_____/_____/_____

Patient DOB:_____

Please tell us your contact information.

Home Phone: ( ) _____-_____

Work Phone: ( ) _____-_____

Cell Phone: ( ) _____-_____

e-mail address: _____

****

Please indicate below who we are allowed to disclose your personal health information to. This may include appointments, treatment performed, treatment diagnosed, etc. Please indicate their name and relationship to you OR select "no one but myself" if applicable.

No one but myself____

Name_____ Relation_____

Name_____ Relation_____

Name_____ Relation_____

****

CONTINUED ON BACK---->>>>>

If at any time you wish to change the information provided on this form, please ask for a new form prior to your appointment so your chart can be updated. If you have any questions regarding the HIPAA regulations, please do not hesitate to ask.

Please review the following and initial and sign where appropriate.

_____ initial **I am presenting myself for diagnosis and treatment for the dentists and/or dental assistants and hygienists of McComb Family Dental. I voluntarily consent to the providing of such care including diagnostic procedures and dental treatments by providers and staff as may, in their judgement, be necessary or advisable to treat my condition.

_____initial **I understand that I am entitled to a copy of McComb Family Dental Notice of Privacy Practices as set forth by HIPAA regulations if requested.

_____initial **I understand that it is my responsibility to update my HIPAA release of information. I also understand that this can be done at any time by contacting the office directly.

_____initial **I authorize the release of medical/dental information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims and prescriptions. I also authorize payment of dental benefits to the rendering dentist.

_____ _____/_____/_____

Patient/Guardian Signature Date

_____

If not signed by patient, please indicate relationship to patient

McCOMB
FAMILY DENTAL

Dental Insurance Form

Patient Name: _____ Date: _____/_____/_____

PRIMARY:

Insured's Name: _____ Insured's Birthdate: _____/_____/_____

Insured's Employer: _____ Relation: _____

Insured's SSN #: _____ Insured's ID #: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone #: _____ Group #_____

SECONDARY:

Insured's Name: _____ Insured's Birthdate: _____/_____/_____

Insured's Employer: _____ Relation: _____

Insured's SSN #: _____ Insured's ID #: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone #: _____ Group #_____