(614) 764-1013
waddelldds@powelldentalcare.net

Powell Dental Care

9733 C Sawmill Parkway
Powell, Ohio 43065

Patient Information

Name: _____ SS#: _____ Birth Date: _____

Address: _____ _____ ____ _____
Street City ST ZIP

Home Phone _____ Cell Phone _____ Email _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Patient or Parent's Employer: _____ Work Phone: _____

Spouse or Parent's Name: _____ Employer: _____

Spouse or Parent's Work Phone: _____

Referred by? _____

Person to Contact in Case of Emergency: _____ Phone: _____

Responsible Party

Name of Person Responsible for this Account: _____

Relationship to Patient: _____ SS#: _____ Birth Date: _____

Address: _____ _____ ____ _____
Street City ST ZIP

Home Phone _____ Cell Phone _____ Email _____

Employer: _____ Work Phone: _____

Insurance Information

Name of Insured: _____

Relationship to Patient: _____ SS#: _____ Birth Date: _____

Name of Employer: _____ Work Phone: _____

Insurance Company: _____ Group # _____ ID # _____

Ins. Co. Address: _____ _____ ____ _____
Street City ST ZIP

Secondary Insurance Information

Name of Insured: _____

Relationship to Patient: _____ SS#: _____ Birth Date: _____

Name of Employer: _____ Work Phone: _____

Insurance Company: _____ Group # _____ ID # _____

Ins. Co. Address: _____ _____ ____ _____
Street City ST ZIP

Consent: The undersigned hereby authorizes the doctor or qualified personnel to take radiographs (X-rays), study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis for the purpose of dental treatment and care. I also authorize the doctor to perform any and all treatments and therapy and prescribe medications that may be needed for dental care for the patient named above. I further authorize and consent that the doctor may choose and employ such assistance as he/she deems fit. I also understand that the anesthetic agents embodies a certain risk. I understand that the responsibility for payment of dental services provided in this office for myself or my dependents is mine; due and payable at the time of services are rendered, unless an extended payment plan is arranged with the business office. There is a $35.00 charge for all returned checks. In the event of default, I promise to pay legal interest on the indebtedness, collection costs, and related legal fees.

Signature: _____ Date: _____

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Powell Dental Care
Patient Dental History

9733 C Sawmill Parkway
Powell, Ohio 43065

To help us meet all your dental healthcare needs, please complete this form. If you have any questions or need assistance, please call us, 614-764-1013, we will be happy to help.

Name: _____ Birth Date: _____

Purpose of initial visit: _____

Are you aware of a problem? _____

How long since your last dental visit? _____

Were dental x-rays taken? _____

Previous dentist's name: _____

Previous dentist's address: _____ _____
City Zip

Previous dentist's phone number: _____

Are you happy with the appearance of your teeth?	❑ Yes	❑ No	☐ Don't Know
Have you had any problems or complications with previous dental treatment?	❑ Yes	❑ No	❑ Don't Know
If yes, explain: _____			
1. Do you clench or grind your teeth?	☐ Yes	❑ No	❑ Don't Know
2. Does your jaw click or pop?	❑ Yes	❑ No	❑ Don't Know
3. Have you experienced any pain or soreness in the muscles of your face or around your ear?	❑ Yes	❑ No	❑ Don't Know
4. Do you have frequent headaches, neck aches or shoulder aches?	❑ Yes	❑ No	❑ Don't Know
5. Do you snore?	❑ Yes	❑ No	❑ Don't Know
6. Does food get caught in your teeth?	❑ Yes	❑ No	❑ Don't Know
7. Do your gums bleed or hurt? When? _____	❑ Yes	❑ No	❑ Don't Know
8. Do you experience dry mouth?	❑ Yes	❑ No	❑ Don't Know
9. Do you feel your breath is offensive at times?	☐ Yes	❑ No	❑ Don't Know

10. Are any of your teeth sensitive to: ❑ Hot ❑ Cold ❑ Sweets ❑ pressure

Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? Explain: _____

In submitting this form, I agree that to the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature: _____ Date: _____

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Powell Dental Care

Patient Medical History

9733 C Sawmill Parkway
Powell, Ohio 43065

To help us meet all your dental healthcare needs, please complete this form. If you have any questions or need assistance, please call us, 614-764-1013, we will be happy to help.

Name: _____ Birth Date: _____

Primary Care Physician Name: _____ Phone Number: _____

Are you under a physician's care now? Yes ☐ No ☐
If yes, please explain: _____

Have you been hospitalized or had a major operation? Yes ☐ No ☐
If yes, please explain: _____

Have you had a serious head or neck injury? Yes ☐ No ☐
If yes, please explain: _____

Are you taking any medications, pills, drugs, or vitamins/supplements? Yes ☐ No ☐
If yes, please explain: _____

Are you on a special diet? Yes ☐ No ☐

Do you use tobacco? Yes ☐ No ☐

Do you use controlled substances? Yes ☐ No ☐

Do you have any sleep concerns? Yes ☐ No ☐

Have you been told you snore? Yes ☐ No ☐

For Women:

Are you pregnant/trying to get pregnant? Yes ☐ No ☐

Are you taking oral contraceptives? Yes ☐ No ☐

Are you nursing? Yes ☐ No ☐

Please list all known allergies:

Please continue to Page 2 of the Medical History form...

Powell Dental Care

Please select any medical conditions that you may presently have or have had. *Medical history Page 2 continued*

- ❑ AIDS/HIV Positive
- ❑ Alzheimer's Disease
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis/Gout
- ❑ Artificial Heart Valve
- ❑ Artificial Joint
- ❑ Asthma
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Problem
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chest Pains
- ❑ Cold Sores/Fever Blisters
- ❑ Congenital Heart Disorder
- ❑ Convulsions
- ❑ Cortisone Medicine
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Easily Winded
- ❑ Emphysema
- ❑ Epilepsy or Seizures
- ❑ Excessive Bleeding
- ❑ Excessive Thirst
- ❑ Fainting Spells/Dizziness
- ❑ Frequent Cough
- ❑ Frequent Diarrhea
- ❑ Frequent Headaches
- ❑ Genital Herpes
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Heart Attack/Failure
- ❑ Heart Murmur
- ❑ Heart Pacemaker
- ❑ Heart Trouble/Disease
- ❑ Hemophilia
- ❑ Hepatitis B or C
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Hives or Rash
- ❑ Hypoglycemia
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Mitral Valve Prolapse
- ❑ Osteoporosis
- ❑ Pain in Jaw Joints
- ❑ Parathyroid Disease
- ❑ Psychiatric Care
- ❑ Radiation Treatments
- ❑ Recent Weight Loss
- ❑ Renal Dialysis
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Trouble
- ❑ Sleep Apnea
- ❑ Spina Bifida
- ❑ Stomach/Intestinal Disease
- ❑ Stroke
- ❑ Swelling of Limbs
- ❑ Thyroid Disease
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors or Growths
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Yellow Jaundice

Any serious illness not listed above?_____

_____

In submitting this form, I agree that to the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature: _____ Date: _____

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Powell, Ohio 43065

Notice of Privacy Practices

To help us meet all your dental healthcare needs, please read our privacy practices and fill out the form below. If you have any questions or need assistance, please call us, 614-764-1013, we will be happy to help.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. 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 HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: 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 uses 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.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: *continued on Page 2*

Public Benefit:
We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

•as required by law;
•for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
•to report adult abuse, neglect, or domestic violence;
•to health oversight agencies;
•in response to court and administrative orders and other lawful processes;
•to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
•to coroners, medical examiners, and funeral directors;
•to an organ procurement organizations;
•to avert a serious threat to health or safety;
•in connection with certain research activities;
•to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
•to correctional institutions regarding inmates; and
•as authorized by state worker's compensation laws.

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may—but are not required to—prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for more information about fees.

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). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.
If you believe that:
•we may have violated your privacy rights,
•we made a decision about access to your health information incorrectly,
•our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
•we should communicate with you by alternative means or at alternative locations,
you may contact us using the information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Name: _____

Address:
Street: _____

City: _____

State: _____ **Zip**: _____

Telephone: _____

☐ I acknowledge that I have received and read a Notice of Privacy Practices from the above named practice.

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Powell Dental Care

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Powell, Ohio 43065

Thank you for choosing Powell Dental Care. Our primary focus is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care easy and manageable for our patients by offering several payment options.

Payment Options

You can choose from:

- Cash, Check, Visa, MasterCard, Discover, American Express, Care Credit

Please note:

Powell Dental Care requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For treatment plans requiring more than 2 appointments and over $500.00, alternative payment arrangements may be provided.

A fee of $35.00 is charged for patients who miss or cancel more than 1 time in a calendar year without a 48-hour notice. There is a $35.00 charge for returned checks. If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

If submitting this online, please save to your desktop and then click "submit"

SUBMIT