Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us - we will be happy to help.

Office Use only:

Patient Information (Confidential)

Patient #_____

Date_____

Name_____ Birthday_____ Soc Sec#_____
First M Last

Address_____City_____State_____Zip_____

Home Phone ( )_____Work Phone ( )_____

Check Appropriate Box ( ) Minor ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

If College Student Full Part
Name of College_____City_____St. _____ ( ) Time ( ) Time

Whom May We Thank for Referring You?_____

Responsible Party

Name of Person Relationship
Responsible for this account_____To Patient_____

Address _____Home Phone_____

Responsible Party Date of Birth_____Soc. Sec. #_____

Employer_____Work Phone_____
Is This Person Currently a Patient in Our Office? ( ) Yes ( ) No

Financial:

For your Convenience we accept the following methods of payment: Cash, Personal Check, Visa, Mastercard and Discover. Payment in full..... unless prior arrangements have been made.
Balances not paid 90 days after date of service may incur 1.5% finance charge.

Deductibles and estimated insurance percentages will be the responsibility of our patients at the time of their service.

As a courtesy to our patients, our office will submit the initial paperwork to your insurance company. Questions relating to individual coverage, resubmission of claims, termination of insurance, as well as any unpaid balance will be the responsibility of the patient.

Insurance Information

Patient Name_____ Relationship to
Name of Insured_____ To Patient_____

Birthdate_____ Soc Sec #_____ Date Employed_____

Name of Employer_____ Union or Local #_____ Work Phone ( ) _____

Insurance Company_____ Gr.#_____ Policy I.D #_____

Insurance Company Address_____ City_____ St._____ Zip_____

Insurance Company Phone Number_____

DO YOU HAVE ADDITIONAL INSURANCE? ( ) Yes ( ) No - If yes complete the following:
Relationship
Name of Insured_____ To Patient_____

Birthdate_____ Social Security #_____ Date Employed_____

Name of Employer_____ Union or Local #_____ Work Phone_____

Insurance Company_____ Group #_____ Policy/ID #_____

Insurance Company Address _____ City_____ State_____ Zip_____

Insurance Company Phone Number_____

Patient Dental History

Name of Previous Dentist and Location_____ Date of Last Exam_____

	Yes	No
1. Do your gums bleed while brushing or flossing.?.....	( )	( )
2. Are your teeth sensitive to hot or cold liquids/foods?.....	( )	( )
3. Are your teeth sensitive to sweet or sour liquids/foods?.....	( )	( )
4. Do you feel pain to any of your teeth?.....	( )	( )
5. Do you have any sores or lumps in or near your mouth?.....	( )	( )
6. Have you had any head, neck or jaw injuries?.....	( )	( )
7. Have you ever experienced any of the following problems in your jaw?		
Clicking.....	( )	( )
Pain (joint, ear, side of face).....	( )	( )
Difficulty in opening and closing.....	( )	( )
Difficulty in chewing.....	( )	( )
8. Do you have frequent headaches?.....	( )	( )
9. Do you clench or grind your teeth?.....	( )	( )
10. Do you bite your lips or cheeks frequently?.....	( )	( )
11. Have you ever had any difficult extractions in the past?.....	( )	( )
12. Have you ever had any prolonged bleeding following extractions?.....	( )	( )
13. Have you had any orthodontic treatment?.....	( )	( )
14. Do you wear dentures or partials?.....	( )	( )
If yes, date of placement_____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?.....	( )	( )

CHILD 'S DENTAL HISTORY (If Applies)

Date of last Dental Visit _____ Type of Treatment_____

Date of last Bite Wing x-Rays_____

Please circle Yes or No to the following:

Des the child have any current dental complaints? Yes No

Nature of Complaint_____

Has the child had any unhappy dental experiences? Yes No

Does the child have any mouth habits: Yes No

Please circle those which apply: Pacifier Nail Biting Thumb Sucking Mouth Breathing

Has child ever received a tooth or mouth injury? Yes No

Please describe injury_____

Does your child exhibit any unusual speech habits? Yes No

Has your child ever had orthodontic treatment? Yes No .....When_____

How often does your child brush his/her teeth?

How often does your child floss his/her teeth?

Is fluoride taken in any form? Yes No

How does your child feel about dental visits? _____

Do you desire complete dental services for your child? Yes No

Eaglesoft Medical History(Copy)(Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Have you been out of the USA in the past 6 months?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Have you ever been told that you require PREMED?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	

Do any of the following apply to you?

Pregnant/Trying to get pregnant?	◯ Yes ◯ No
Nursing?	◯ Yes ◯ No
Taking oral contraceptives?	◯ Yes ◯ No
Taking/Taken any mood altering drugs	◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Nut Allergies			

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain In Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Yellow Jaundice	◯ Yes ◯ No	Acid Reflux	◯ Yes ◯ No	Asbergers/Autism	◯ Yes ◯ No		

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

CONSENT FOR TREATMENT

I hereby authorize Drs. Ely, Dubos, Stewart and staff to perform dental procedures.

You have the right to be informed about your condition and the recommended treatment so that you may make an educated decision as to whether or not to undergo the procedure after knowing the risks and potential complications involved. The disclosure is not meant to alarm you, but is an effort to provide information so that you may give or withhold your consent for treatment.

- I understand that the information 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 history.
- I consent to the necessary diagnostic procedures (including x-rays) to determine recommended treatment; I will decide whether or not I wish to have treatment.
- I understand that although this office has a high degree of clinical success yet, reasons beyond our control may limit the guarantee. For example occasionally a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.
- I understand that a tooth may have a fractured root which cannot always be detected from oral examination or x-rays. If this condition is found, extraction will be necessary.
- I understand and agree that I will participate in my treatment plan and that I may discontinue treatment and/or withdraw my consent for treatment at any time.
- I acknowledge full responsibility for the payment of such services and agree to pay for them in full, unless other specific arrangements are made with the treatment coordinator. I understand that my dental insurance carrier may pay less that the actual bill for services, and I am responsible for the entire fee, regardless of my insurance company's arbitrary determination of "usual and customary rates."
- I authorize my insurance carrier to issue the dental benefits of my plan directly to this dental office. I also authorize release of information necessary to process dental insurance.
- If patient is a minor, I authorize consent for Drs. Ely, Dubos, Stewart and Staff to render services as proposed and scheduled under the general supervision of the licensed dentist on staff. I agree to assume financial responsibility for all expenses of such care.
- If I am late the amount of time equivalent to half of my scheduled appointment time, the office reserves the right to reschedule me.
- If the office finds there to be a repetitive history of late notice cancelations or no shows, we reserve the right to charge the patient a fee of $50.00.

_____

Signature

FINANCIAL GUIDELINES FOR OUR PATIENTS

For our Patients with Insurance:

As a courtesy to our patients we will submit claims to any insurance company, whether in or out of network, with the exception of Medicaid and DMO plans. Questions regarding plan coverage, percentages, PPO's, networks, limits and maximums are ultimately the patient's responsibility. However, we would be glad to provide you with an estimate, based on past computer entries of what your insurance company may pay. Please realize this is an "estimation" and not a guarantee of payment. Procedures not covered, deductible and co-insurance amounts are payable at the time of service unless prior arrangements have been made.

For our Patients without Insurance:

Payment for Dental Treatment is required at the time of service. For your convenience our office accepts Visa, Master Card, and Discover. We also provide assistance with American General Finance for larger dental cases. If you are interested in using American General Finance please ask one of our staff for more information.

Thank you

ELY, DUBOS & STEWART, D.D.S., INC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement "

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ Date: _____

Signature

For Office Use Only

We attempted to obtain Written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)

NOTICE OF PRIVACY PRACTICES

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

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required 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 that are described in this Notice while it is in effect. This Notice takes effect 01/01/03, 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 changes are permitted by applicable law. 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 healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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 use 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 must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also 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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

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

PATIENT RIGHTS

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 obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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 will 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 a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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.

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).

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.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled 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 the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. 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.

Contact Officer: TERESA WORKMAN

Telephone: 740-474-1900 Fax: 740-474-1900

E-mail: _____

Address: 1200 Lancaster Pike
Circleville, OHIO 43113