Eastern Hills Dental
www.easternhillsdentalcincy.com
7655 Five Mile Road, Suite 222 • Cincinnati, OH 45230
EHDCincy@gmail.com
(513)231-7474

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other **Prev. Visit:** _____
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Phone:** _____ _____ _____
Home Mobile Work

Email Address: _____

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Whom may we thank for referring you to our practice?

_____

We may contact you for communication about appointments through email, text messages, or phone calls. Please indicate if you prefer NOT to be contacted by any one of these methods.

_____

In an emergency, who should be notified? Please list name, phone number, and relationship to patient.

_____

Primary Dental Insurance, if applicable:

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

Do you have Secondary Dental Insurance? ◯ Yes ◯ No

If yes, please provide secondary insurance information directly to our front office staff. _____

☐ By checking this box, I authorize my insurance to pay my benefits directly to the dentist for all services 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.

Medical History

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Indicate which of the following applies to the patient:

☐ Acid Reflux / GERD	☐ Allergy - Seasonal	☐ Allergy - Medication (list below)	☐ Anemia or other Bleeding Disorder
☐ Anxiety/Depression	☐ Arthritis	☐ Artificial Joints	☐ Asthma
☐ Bisphosphonate Use	☐ Cancer	☐ Chemotherapy	☐ COPD
☐ Diabetes	☐ Epilepsy/Seizures	☐ Endocarditis	☐ Fainting
☐ Head Aches/ Migraines	☐ Head or Neck Injuries	☐ Heart Disease/ Heart Attack	☐ Heart Murmur/ MVP
☐ Heart Surgery	☐ Heart Valve Replacement	☐ Hepititis	☐ High Blood Pressure
☐ High Cholesterol	☐ HIV/AIDS	☐ Kidney Disease	☐ Latex Allergy
☐ Liver Disease	☐ Nervous System Disorder	☐ Osteoporosis	☐ Pacemaker
☐ Psychiatric Condition	☐ Radiation Treatment	☐ Respiratory Condition	☐ Rheumatoid Arthritis
☐ Sinus Infections	☐ Sleep Apnea	☐ Stomach Condition	☐ Stroke
☐ Thyroid Disorder	☐ Tobacco Use	☐ Tuberculosis	☐ Venereal Disease

If any box selected above needs further clarification, please explain:

_____

_____

List all current medications, supplements, and/or vitamins:

_____

_____

List any major surgeries and/or recent hospitializations

_____

_____

Have you taken an antibiotic premedication before your dental visits in the past? ◯ Yes ◯ No

If yes, please list premedication and reason why:

_____

_____

Females: Are you currently pregnant? ◯ Yes ◯ No

Name of current physician and date of most recent exam:

_____

_____

BP Today (Leave Blank. Blood Pressure will be taken by office staff) _____

_____

☐ ***By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.**

Dental History

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist's name: _____

Date of most recent dental exam and xrays: _____

I routinely see my dentist every:

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

What is your immediate concern?

_____

_____

Personal History, Check all that apply:

☐ Had an unfavorable dental experience ☐ Had complications from past dental treatment ☐ Had trouble getting numb

☐ Had/have braces, orthodontic treatment ☐ Had your bite adjusted

Smile Characteristics, Check all that apply:

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

☐ Have you ever whitened (bleached) your teeth?

☐ Have you felt uncomfortable or self conscious about the appearance of your teeth?

☐ Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint, Check all that apply:

☐ You have problems with your jaw joint

☐ Your teeth changed in the last 5 years, became shorter, thinner, or worn

☐ Your teeth crowding or developing spaces

☐ You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits

☐ You clench your teeth in the daytime or make them sore

☐ You have problems with sleep or wake up with an awareness of your teeth

☐ You wear or have worn a bite appliance

Tooth structure, Check all that apply:

☐ The amount of saliva in your mouth seems too little or you have difficulty swallowing any food

☐ You notice or have holes (i.e. pitting, craters) on the biting surface of your teeth

☐ Any teeth sensitive to hot, cold, biting, sweets, or you avoid brushing any part of your mouth

☐ Any teeth with grooves, notches, chips, a cracked filling or pain

☐ Food gets caught between any teeth

Gum and Bone, Check all that apply:

☐ Gums bleed when brushing or flossing

☐ Treated for gum disease or were told you have lost bone around your teeth

☐ History of periodontal disease in your family

☐ Experienced gum recession

☐ Had any teeth become loose on their own (without injury)

If any of the checked boxes need further explanation, please describe:

_____

_____

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made. Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

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

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

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

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ ***I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Signature _____ **Date** _____

Response Date: ____/____/_____