TIME 10:44 AM

DATE 7/12/2011

PATIENT REGISTRATION

ID: ________ Chart ID: ________________

First Name: ________________ Last Name: ________________ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: ________________

Responsible Party (If someone other than the patient)

First Name: ________________ Last Name: ________________ Middle Initial: ____

Address: ________________ Address 2: ________________

City, State, Zip: ________________ Pager: ________________

Home Phone: ________ Work Phone: ________ Ext: ____ Cellular: ________

Birth Date: ________ Soc Sec: ________ Drivers Lic: ________

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: ________________ Address 2: ________________

City: ________________ State / Zip: ____ ________ Pager: ________________

Home Phone: ________ Work Phone: ________ Ext: ____ Cellular: ________

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: ________ Age: ____ Soc. Sec: ________ Drivers Lic: ________

E-mail: ________________ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: ________ Pref. Dentist: ________

Employer ID: ________ Pref. Pharmacy: ________

Carrier ID: ________ Pref. Hyg.: ________

Section 3

Additional Comments:

Primary Insurance Information

Name of Insured: ________________ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: ________ Insured Birth Date: ________

Employer: ________________

Address: ________________

Address 2: ________________

City,State,Zip: ________________

Ins. Company: ________________

Address: ________________

Address 2: ________________

City,State,Zip: ________________

Rem. Benefits: ________.00 Rem. Deduct: ________.00

Secondary Insurance Information

Name of Insured: ________________ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: ________ Insured Birth Date: ________

Employer: ________________

Address: ________________

Address 2: ________________

City,State,Zip: ________________

Ins. Company: ________________

Address: ________________

Address 2: ________________

City,State,Zip: ________________

Rem. Benefits: ________.00 Rem. Deduct: ________.00

Time 9:57 AM

Old School Dental

Old School Dental Med History

Date 8/1/2018

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

Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes

Do you use tobacco? ○ Yes ○ No

Do you use controlled substances? ○ Yes ○ No If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

Other? ☐ If yes

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

AIDS/HIV Positive	○ Yes ○ No	Radiation Treatments	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Angina	○ Yes ○ No
High Blood Pressure	○ Yes ○ No	Arthritis/Gout	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No	Artificial Joint	○ Yes ○ No
Asthma	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Stroke	○ Yes ○ No	Cancer	○ Yes ○ No
Glaucoma	○ Yes ○ No	Chemotherapy	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Chest Pains	○ Yes ○ No
Heart Attack/Failure	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Congenital Heart Disorder	○ Yes ○ No
Heart Pacemaker	○ Yes ○ No	Psychiatric Care	○ Yes ○ No				

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

Comments:

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 of Patient, Parent or Guardian:

X

Date:________

Jonah Staten, DDS
1028 Columbus St. SW
Etna, OH 43018
(740) 927-7645

HIPAA PRIVACY AUTHORIZATION FORM

DATE:____________________________

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITIED AUTHORIZATION AND RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for the healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

______________________________ ______________________________

Patient name(s) (please print) Signature of patient, parent or guardian

Please list any other parties who can have access to your health information (this includes step parents, grandparents and any care takers who can have access to this patient's records):

Name:______________________________ Relationship:______________________
Name:______________________________ Relationship:______________________
Name:______________________________ Relationship:______________________

I authorize contact from this office to confirm my appointments, treatment & billing information via:

- _ Cell phone confirmation
- _ Home phone confirmation
- _ Work phone confirmation
- _ Text message to my cell phone
- _ Email Confirmation
- _ Any of the above

I authorize information about my health be conveyed via:

- _ Cell phone confirmation
- _ Home phone confirmation
- _ Work phone confirmation
- _ Text message to my cell phone
- _ Email Confirmation
- _ Any of the above

I approve being contacted about special services, events, fund raising efforts or new health info on behalf of this Healthcare Facility via:

- _ Phone message
- _ Text message
- _ Email
- _ Any of the above
- _ None of the above (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office use only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this acknowledgement but did not because:

- It was emergency treatment ___
- I could not communicate with the patient ___
- The patient refused to sign ___
- The patient was unable to sign because ___
- Other (please describe) ___

____

Signature of Privacy Officer______________________________