

*Welcome to Pataskala Family Dental*

*Michael D. Shvallow, D.D.S.*

PATIENT INFORMATION	CONFIDENTIAL
<p>NAME _____</p> <p>ADDRESS _____</p> <p>CITY _____ STATE _____ ZIP _____</p> <p>PATIENT OR PARENT'S EMPLOYER _____</p> <p>BUSINESS ADDRESS _____</p> <p>CITY _____ STATE _____ ZIP _____</p> <p>IF PT IS A STUDENT, NAME OF SCHOOL _____</p> <p>CITY _____ STATE _____</p> <p>How did you hear about us? _____</p> <p>E-mail Address _____</p>	<p>BIRTHDATE _____</p> <p>HOME PHONE _____</p> <p>_____</p> <p>CIRCLE APPROPRIATE SELECTION:</p> <p>MINOR    SINGLE    MARRIED</p> <p>DIVORCED    WIDOWED    SEPERATED</p> <p>WORK PHONE _____</p> <p>CELL PHONE _____</p> <p>OTHER _____</p>
RESPONSIBLE PARTY	
<p>NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____</p> <p>_____</p> <p>ADDRESS _____</p> <p>CITY _____ STATE _____ ZIP _____</p> <p>EMPLOYER _____</p> <p>ADDRESS _____</p> <p>CITY _____ STATE _____ ZIP _____</p>	<p>RELATIONSHIP TO PATIENT _____</p> <p>HOME PHONE _____</p> <p>WORK PHONE _____</p> <p>CELL PHONE _____</p> <p>BIRTHDATE _____</p> <p>SS NUMBER _____</p>
INSURANCE INFORMATION	
<p>NAME OF INSURED _____</p> <p>INSURANCE COMPANY _____</p> <p>ADDRESS _____</p> <p>CITY _____ STATE _____ ZIP _____</p>	<p>RELATIONSHIP TO PATIENT _____</p> <p>BIRTHDATE _____</p> <p>SS NUMBER _____</p> <p>GROUP NUMBER _____</p> <p>INSURANCE PHONE _____</p>

PATIENT NAME \_\_\_\_\_

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**ADDITIONAL INSURANCE**

NAME OF INSURED \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_

BIRTHDATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

SS NUMBER \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

GROUP NUMBER \_\_\_\_\_

INSURANCE PHONE \_\_\_\_\_

**PATIENT MEDICAL HISTORY**

PHYSICIAN NAME \_\_\_\_\_

PHYSICIAN PHONE \_\_\_\_\_

- ARE YOU UNDER THE CARE OF A PHYSICIAN                      YES    NO
- HAVE YOU BEEN HOSPITALIZED IN THE LAST FIVE YEARS                      YES    NO
- ARE YOU TAKING MEDICATIONS? INCLUDING OVER THE COUNTER AND PRESCRIPTION.                      YES    NO
- DO YOU USE TOBACCO?                      YES    NO
- DO YOU USE ALCOHOL?                      YES    NO
- DO YOU USE COCAINE OR OTHER DRUGS?                      YES    NO
- DO YOU WEAR CONTACTS?                      YES    NO
- DO YOU HAVE ANY ALLERGIES?                      YES    NO

DATE OF LAST EXAM \_\_\_\_\_

LIST MEDICATIONS  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- ARE YOU ALLERGIC TO LATEX?                      YES    NO
- HAVE YOU EVER HAD A REACTION TO ANESTHETIC? YES    NO

**WOMEN ONLY:**

- ARE YOU PREGNANT \_\_\_\_\_
- ARE YOU NURSING \_\_\_\_\_
- ARE YOU TAKING BIRTH CONTROL PILLS \_\_\_\_\_

EXPLAIN ANY "YES" ANSWERS FROM ABOVE:  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS ABOUT YOURSELF:

(MARK ALL ANSWERS WITH A YES OR NO)

	YES	NO		YES	NO		YES	NO
HIGH BLOOD PRESSURE	___	___	FREQUENTLY TIRED	___	___	KIDNEY DISEASE	___	___
HEART ATTACK	___	___	ANEMIA	___	___	AIDS/HIV INFECTION	___	___
RHEUMATIC FEVER	___	___	EMPHYSEMA	___	___	STD'S	___	___
SWOLLEN ANKLES	___	___	CANCER	___	___	THYROID PROBLEMS	___	___
FAINING/SEIZURES	___	___	ARTHRITIS	___	___	HEPATITIS A, B OR C	___	___
ASTHMA	___	___	JOINT REPLACEMENT	___	___	ULCERS	___	___
LOW BLOOD PRESSURE	___	___	CHEST PAINS	___	___	RESPIRATORY PROBLEMS	___	___
EPILEPSY/CONVULSIONS	___	___	SHORT OF BREATH	___	___	PSYCHIATRIC PROBLEMS	___	___
LEUKEMIA	___	___	STROKE	___	___	OTHER	___	___
DIABETES	___	___	HAY FEVER/ALLERGIES	___	___	_____		
HEART DISEASE	___	___	TUBERCULOSIS	___	___	_____		
CARDIAC PACE MAKER	___	___	RADIATION THERAPY	___	___	_____		
HEART MURMER	___	___	GLAUCOMA	___	___	_____		
ANGINA	___	___	LIVER DISEASE	___	___	_____		

PATIENT NAME \_\_\_\_\_

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**PATIENT DENTAL HISTORY**

- |   |       |    |
|---|-------|----|
| 1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?               | YES   | NO |
| 2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?       | YES   | NO |
| 3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?     | YES   | NO |
| 4. DO YOU FEEL PAIN IN ANY OF YOUR TEETH?                       | YES   | NO |
| 5. DO YOU HAVE ANY SORES OR LUMPS IN YOUR MOUTH?                | YES   | NO |
| 6. HAVE YOU EVER SUFFERED TRAUMA TO YOUR FACE MOUTH OR JAW?     | YES   | NO |
| 7. DOES YOUR JAW EVER CLICK, POP, CRACKLE OR ACHE?              | YES   | NO |
| 8. DO YOU HAVE PAIN IN YOUR JAW JOINT, EAR OR SIDE OF THE FACE? | YES   | NO |
| 9. DO YOU HAVE DIFFICULTY OPENING OR CLOSING YOUR MOUTH?        | YES   | NO |
| 10. DO YOU HAVE DIFFICULTY CHEWING?                             | YES   | NO |
| 11. DO YOU HAVE FREQUENT HEADACHES?                             | YES   | NO |
| 12. DO YOU CLINCH OR GRIND YOUR TEETH?                          | YES   | NO |
| 13. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?                 | YES   | NO |
| 14. HAVE YOU PROBLEMS WITH PREVIOUS DENTAL WORK?                | YES   | NO |
| 15. HAVE YOU EVER HAD BRACES?                                   | YES   | NO |
| 16. HOW MANY TIMES A DAY DO YOU BRUSH YOUR TEETH?               | _____ |    |
| 17. HOW OFTEN DO YOU FLOSS?                                     | _____ |    |
| 18. DO YOU USE A MANUAL BRUSH OR ELECTRIC?                      | _____ |    |
| 19. DO YOU USE ANY TYPE OF MOUTH RINSE?                         | YES   | NO |

TELL ME WHAT YOU LIKE ABOUT YOUR SMILE: \_\_\_\_\_

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD THAT BE? \_\_\_\_\_

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINT NAME

## Pataskala Family Dental

## Privacy Notice

***This notice describes how medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.***

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at (740) 964-5138.

### *Information We Collect About You*

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

### *How Your Information Is Used*

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. Pataskala Family Dental does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment.

### *Safeguarding Your Personal and Health Information*

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Pataskala Family Dental maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Pataskala Family Dental.

### *Changes to Our Privacy Policy*

All new patients will review a copy of our privacy policy. Pataskala Family Dental occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

### *Your Right to Restrict Use of Information*

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

### Patient Acknowledgement

I \_\_\_\_\_ have reviewed Pataskala Family Dental's Privacy Policy.

Signed \_\_\_\_\_ Date

# Pataskala Family Dental

## OFFICE POLICY AND CONSENT FORM

Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of dental care.

### INSURANCE AND PAYMENT POLICIES

- **FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT.** For treatment involving fees above \$500.00, special 3<sup>rd</sup> party financial arrangements may be discussed with our office manager.

- For patients with Dental Insurance:

**We will file your claim for you at *no charge*, however, we ask that your deductibles and your estimated portions (20-60%) be paid as services are rendered. Although we gladly file dental insurance claims, any and all account balances are ultimately your responsibility.**

All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.

- Please note for your convenience, we do accept VISA, MasterCard, Discover, Citi Health Card and Care Credit as well as checks and cash.

### OFFICE POLICIES

- When we reserve an appointment for you for **Major Dental Procedures** we will ask that you pay **½ of your co-pay** at the time you make the appointment and **pay the balance at the appointment.** We set aside this quality time for you to assure that we can have enough appointments available for patients who want to be seen. We take deposits on major dental procedures to help ensure that our patients will have quality appointment time and keep their scheduled times.
- Your appointment time is set aside especially for you. We ask for courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we would appreciate a 48-hour notice.** Cancellations or missed appointments will result in a **broken appointment charge or no reappointment.**
- We realize that many families are in a state of change. **The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.**
- We will be fair in working out special finances with you, but please also be fair to us with your commitments. **A 1.5% finance charge will be assessed monthly on all overdue balances.** I understand that if I am delinquent on my obligation to pay Pataskala Family Dental, then I will be responsible for any late fees, interest charges, court costs, attorney fees, and collection charges should the balance not be paid in due diligence

### CONSENT:

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Date \_\_\_\_\_ Signature \_\_\_\_\_ (Patient, Parent or Guardian)

# Oral Health Risk Assessment Test

Good oral health depends on a variety of factors including oral hygiene habits, food consumption, family oral health history and regular visits to the dental office. Our practice is participating in a national consumer survey to help assess oral hygiene habits in the United States. This program is sponsored by 3M ESPE, the dental products business of 3M Company. Please take a few minutes to provide honest answers to the questions below. Your identity will not be revealed to anyone outside of our office. The data from this program will provide the dental profession with valuable information about the oral health status of the general population.

Your answers will also be reviewed by our staff to help us determine the most appropriate office treatment and home care therapy for your particular situation. Based on today's dental examination and a review of your answers, we may recommend additional steps you should take to maintain or improve your oral health.



Please circle your answer.		
	Yes	No
Do you brush your teeth two or more times per day?	Yes	No
Do you floss every day?	Yes	No
Does your drinking water contain fluoride?	Yes	No
Do you snack between meals?	No	Yes
Do you frequently consume food high in sugars?	No	Yes
Have you had any fillings in the last three years?	No	Yes
Do you use any tobacco products?	No	Yes
Do you frequently have "dry mouth"?	No	Yes
Are your teeth sensitive to hot, cold or certain foods?	No	Yes
Do you drink alcohol more than three days per week?	No	Yes
Are you undergoing chemotherapy or radiation treatments?	No	Yes
Do you wear braces?	No	Yes
Has anyone in your immediate family had any fillings in the last three years?	No	Yes
Has anyone in your immediate family been treated for gum disease in the last three years?	No	Yes
<b>Total answers circled per column:</b>		

Dentist Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Your Zip Code: \_\_\_\_\_

Patient Age:  12 years and under  13-18 years  19-34 years  35-54 years  55 years and over

Race:  White  African American  Latino  Asian  Other \_\_\_\_\_

Education:  High school  College Sex:  Male  Female

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