## NEW PATIENT INFORMATION FOR COMPUTER

LAST NAME _____ FIRST NAME _____ MI ____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ WORK PHONE # _____

CELL PHONE # _____ E-MAIL _____

SS# _____ D.O.B. _____

REFERRING DOCTOR _____

## DENTAL INSURANCE INFORMATION

**PLEASE NOTE:** We do not accept Medicare or Medicaid insurance.

PRIMARY INSURED'S NAME _____

SS# _____ D.O.B. _____

EMPLOYER _____

DENTAL INSURANCE COMPANY _____

ADDRESS _____

PHONE # _____ GROUP # _____ ID# _____

RELATIONSHIP TO PATIENT _____

SECONDARY INSURED'S NAME _____

SS# _____ D.O.B. _____

EMPLOYER _____

DENTAL INSURANCE COMPANY _____

ADDRESS _____

PHONE # _____ GROUP # _____ ID# _____

RELATIONSHIP TO PATIENT _____

Akron Periodontics & Dental Implantology
484 S. Miller Road
Akron, Ohio 44333-4119

Drug Reactions/Allergies _____

# MEDICAL HISTORY FORM

LAST NAME | FIRST | M.I. | BIRTHDATE | HEIGHT | WEIGHT | MARITAL STATUS

HOME ADDRESS | CITY | STATE | ZIP | HOME TELEPHONE

EMPLOYER | OCCUPATION | SOCIAL SECURITY # | BUSINESS TELEPHONE

NAME OF HUSBAND, WIFE or PARENT | DENTAL INSURANCE | CELL PHONE

REFERRED BY | NAME OF DENTIST | NAME OF PHYSICIAN

TELEPHONE

1. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ..... Yes No
2. Has there been any change in your general health within the past year? ..... Yes No
3. My last physical examination was on _____
4. Are you now under the care of a physician. ..... Yes No
   If so, what is the condition being treated? _____
5. Are you taking any medicine(s) including non-prescription medicine? ..... Yes No
6. HAVE YOU EVER HAD ANY JOINT REPLACEMENT SURGERY? ..... Yes No
7. Do you or have you had any of the following diseases or problems?
   a. DAMAGED HEART VALVES OR ARTIFICIAL HEART VALVES, INCLUDING HEART MURMUR OR RHEUMATIC HEART DISEASE? ..... Yes No
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ..... Yes No
      1. Do you have chest pain upon exertion? ..... Yes No
      2. Are you ever short of breath after mild exercise or when lying down? ..... Yes No
      3. Do your ankles swell? ..... Yes No
      4. Do you have inborn heart defects? ..... Yes No
      5. Do you have a cardiac pacemaker? ..... Yes No
   c. Allergy, Sinus Trouble, Hay Fever ..... Yes No
   d. Fainting spells or seizures ..... Yes No
   e. Persistent diarrhea or recent weight loss ..... Yes No
   f. Diabetes ..... Yes No
   g. HEPATITIS, jaundice or liver disease ..... Yes No
   h. AIDS or HIV infection ..... Yes No
   i. Thyroid problems ..... Yes No
   j. Respiratory problems, emphysema, asthma ..... Yes No
   k. Arthritis or painful swollen joints ..... Yes No
   l. Stomach ulcer or hyperacidity ..... Yes No
   m. Kidney trouble ..... Yes No
   n. Tuberculosis ..... Yes No
   o. Persistent cough or cough that produces blood ..... Yes No
   p. Persistent swollen glands in neck ..... Yes No
   q. MITRAL VALVE PROLAPSE ..... Yes No
   r. Sexually transmitted disease ..... Yes No
   s. Epilepsy or other neurological disease ..... Yes No
   t. Problems with mental health ..... Yes No
   u. Cancer ..... Yes No
   v. Problems of the immune system ..... Yes No
   w. Frequent severe headaches ..... Yes No
   x. Glaucoma ..... Yes No
8. Have you had abnormal bleeding? ..... Yes No
   a. Have you ever required a blood transfusion? ..... Yes No
9. Do you have any blood disorder such as anemia? ..... Yes No
10. Have you ever had any treatment for a tumor or growth? ..... Yes No
11. Have you ever had radiation or chemotherapy treatments? ..... Yes No
12. Are you allergic or have you had a reaction to:
    a. Local anesthetics ..... Yes No
    b. Penicillin or other antibiotics ..... Yes No
    c. Sulfa drugs ..... Yes No
    d. Barbiturates, sedatives, or sleeping pills ..... Yes No
    e. Aspirin ..... Yes No
    f. Iodine ..... Yes No
    g. Codeine or other narcotics ..... Yes No
    h. Latex ..... Yes No
    I. Other _____
13. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
    If so, explain _____
14. Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No
    If so, explain _____
15. Are you wearing contact lenses? ..... Yes No
16. Are you wearing removable dental appliances? ..... Yes No
17. Have you ever had severe pains of the face and head ..... Yes No

**WOMEN**

18. Are you pregnant? ..... Yes No
19. Do you have any problems associated with your menstrual period? ..... Yes No
20. Are you nursing? ..... Yes No
21. Are you taking birth control pills? ..... Yes No

**DENTAL**

1. Do your gums bleed when you brush your teeth? ..... Yes No
2. Have you ever had excessive bleeding following extraction of teeth or from a cut? ..... Yes No
3. Have you ever been told not to take novocaine? ..... Yes No
4. Do your teeth feel sore when you bite on them? ..... Yes No
5. Do any teeth feel high or long when you bite on them? ..... Yes No
6. Do you grind or clench your teeth when you are nervous or while sleeping? ..... Yes No

**Chief Dental Complaint** _____

**List Drugs Now Being Taken** _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

**AUTHORIZATION**

I hereby authorize payment directly to the undersigned dentist of the surgical, dental, and/or Major Medical benefits, if any, otherwise payable and will pay any outstanding bill for services not covered by my insurance.

If I am turned over to a collection agency for non-payment of my bill, I agree to pay any and all fees incurred for this collection by the agency or attorney involved.

I, also, authorize the undersigned dentist to release any information and/or x-rays acquired in the course of my examination or treatment to my insurance company, and acknowledge that a photostatic copy of this authorization is as valid as the original.

Mark S. Obernesser, D.D.S., M.M.Sc., Inc.

_____
Signature of Patient

_____
Date

AKRON
PERIODONTICS & DENTAL
IMPLANTOLOGY

# 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.

_____
Please Print Name

_____
Signature

_____
Date

**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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

AKRON
PERIODONTICS & DENTAL
IMPLANTOLOGY

# 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 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 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 any time. For more information about out 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).

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## 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 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.

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## 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.

**MARK S. OBERNESSER, D.D.S., M.M.Sc., INC**

***Akron Periodontics and Dental Implantology***

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