Independence Family Dental

6533 Brecksville RD A, Independence, OH 44131
(216) 524-7275

Patient Information

Thank you for choosing our practice for your dental needs. Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Patient Name: _____ Date: _____

SSN: _____ Gender: Male/Female - Family Status: Married Single Child Other

Date of Birth: _____ E-mail: _____

Phone: Home: _____ Cell: _____ Work: _____

Address: _____ City: _____ State: ____ Zip: _____

Emergency Contacts:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Who referred you to Independence Family Dental? _____

Expectations

We respect our patients' time. Therefore we do everything we can do to work efficiently on treatment. We request the same from you. Please be on time and give us a **48 hour notice** if you need to adjust any appointment. All broken appointments will result in a $35.00 per hour fee. ***Please initial:*** _____

We are a zero-balance office. If there is an investment in your health, what method of payment would you use?
Please Circle: Cash Credit Check Financing (Care Credit) HSA

Please initial here if you do not have Dental Insurance/Self-Pay Status: _____

Dental Insurance Information
(Please provide a copy of your Dental Insurance card)

Name of Policy Holder: _____ Birth Date: _____

Member ID/SSN #: _____ Group #: _____

Policy Holder's Employers Name: _____

Patient's Relationship to Policy Holder: ____ Self ____ Spouse ____Child ____Other

Insurance Company: _____ Insured's SSN: _____

Insurance Co. Mailing Address: _____

Health Information

1. Are you taking prescription(s)/over-the-counter or supplement drugs? **YES/NO** If yes, please list medications below:
   _____
2. Do you have any allergies? **YES/NO** If yes, please circle all that apply: Penicillin Antibiotics Anesthetics Aspirin Foods Latex Resins Other: _____
3. Do you require antibiotics before dental treatment? **YES/NO**
   If yes, what premedication (antibiotic) have you been prescribed & who is your prescriber? _____
4. **Women**: Are you pregnant? **YES/NO** Trying to get pregnant? **YES/NO** Are you taking oral contraceptives? **YES/NO**
5. Symptoms or conditions below that you currently HAVE or HAVE HAD in the past year(s): (Please listed the Year Diagnosed (DX))

Alcohol Abuse: **Yes/No** Year Dx:_____
Drug Abuse: **Yes/No** Year Dx:_____
Osteoarthritis: **Yes/No** Year Dx:_____
Anemia: **Yes/No** Year Dx:_____
Liver Problems: **Yes/No** Year Dx:_____
Tobacco Habit: **Yes/No** Year Dx:_____
Osteoporosis: **Yes/No** Year Dx:_____
Stroke: **Yes/No** Year Dx:_____
Artificial Joints: **Yes/No** Year Dx:_____
Tuberculosis: **Yes/No** Year Dx:_____
Heart Murmur: **Yes/No** Year Dx:_____
Heart Ailments/Heart Attack: **Yes/No** Year Dx:_____
Mitral Valve Prolapse: **Yes/No** Year Dx:_____

Rheumatic Fever: **Yes/No** Year Dx:_____
Glaucoma: **Yes/No** Year Dx:_____
Hepatitis A, B, C: **Yes/No** Year Dx:_____
Shingles: **Yes/No** Year Dx:_____
Kidney Disease: **Yes/No** Year Dx:_____
Ulcers/Colitis: **Yes/No** Year Dx:_____
Back Problems: **Yes/No** Year Dx:_____
Rheumatoid Arthritis: **Yes/No** Year Dx:_____
Blood Pressure (High/Low): **Yes/No** Year Dx:_____
Diabetes (I/II/III): **Yes/No** Year Dx:_____
Epilepsy: **Yes/No** Year Dx:_____

Allergies to Medicine(s) : **Yes/No** Year Dx:_____
Sinus problems: **Yes/No** Year Dx:_____
Thyroid Disease: **Yes/No** Year Dx:_____
Asthma: **Yes/No** Year Dx:_____
AIDS/HIV/STDs: **Yes/No** Year Dx:_____
Psychiatric Care: **Yes/No** Year Dx:_____

6. Do you have any other health conditions? **YES/NO** If yes, please explain:
   _____
7. Are you currently taking bisphosphonate /Fosamax? **Yes/No**
8. Do you have history of cancer/chemotherapy/radiation? **YES /NO** Are you currently receiving treatment? **YES/NO**
9. Have you ever been a recipient of an organ transplant? **YES/NO**_____
10. Primary Care Physician _____Phone Number_____
11. Pharmacy Name and Phone Number _____

Independence Family Dental

Trying to accommodate every patient's individual needs and work schedules can be difficult, we always try to do our best. We work very hard to stay on schedule so that our valuable patients will not spend time in our reception area waiting for an appointment.

A scheduled appointment is a commitment of time between you and our practice. We have reserved that time just for you. When appointments are missed or cancelled, that time is permanently lost.

We ask when you schedule an appointment that you make every effort to keep that commitment. We understand that personal emergencies sometimes occur, and we always take that into consideration when receiving a last-minute cancellation.

If you find that you cannot keep your scheduled appointment, we ask that you provide a minimum notice of 48 hours. This allows us to offer this time to another patient in need. Failure to do so will result in a $35.00 per hour missed appointment fee.

From the date of this agreement, each patient is entitled to three missed appointments in the life of the relationship with the practice. After three missed appointments, our office will visit with you regarding our relationship and determine if your dental needs might be better served by another provider. We may alternatively determine that it will be necessary for you to prepay for the services that will be rendered at your ensuing appointments.

If you have any questions, please do not hesitate to ask. We sincerely appreciate your understanding and cooperation with this matter.

_____

Patient signature

_____

Date

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HIPAA Acknowledgement

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? **YES / NO**

May we leave a message on your answering machine at home or on your cell phone? **YES / NO**

May we discuss your medical condition with any member of your family**?** **YES / NO**

If YES, please name the members allowed:

_____

_____

Signature of patient, parent, or guardian (responsible party):

Signature:_____ Date:_____

Relationship to Patient:_____

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Consent for Services

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 or credit card 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 accounts. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% 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 90 days from the date of the patient explanation.

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. 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 permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Relationship to Patient: _____

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