Erieview Dental

General Dentists

9510 Diamond Centre Drive
Mentor, Ohio 44060
Office: 440•357•1222 Fax: 440•357•0418

Patient Information Form

Please Print And Fill Out All Pages Of This Form Completely In Ink.

Patient # _____
(For office use only.)
Soc. Sec. #_____
Date_____

Patient Information: (Confidential)

Name _____ Birth date _____ Home Phone _____

Address _____ City _____ State _____ ZIP _____

E-mail _____ Cell Phone _____

Check appropriate space: Minor _____ Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

If student, name of school/college _____ City_____ State____ Full ____ Part _____

Patient or Parent/Guardian's Employer _____ Work Phone _____

Work Address _____City_____ State _____ ZIP _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone_____

Whom may we thank for referring you? _____

Person to contact in emergency _____ Phone _____

Responsible Party:

Name Of Person Responsible For This Account _____ Relationship _____

Address _____ Phone _____

E-mail _____ Cell Phone _____

Driver's License # _____ State _____ Birth date _____ Bank _____

Employer _____ Work Phone _____ SS# _____

Is This Person Currently A Patient In Our Office? Yes _____ No _____

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash ☐ Check ☐ Credit Card: VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy ☐

Insurance

Patient No.: _____
(For office use only.)

Name of Insured _____ Relationship _____

Birth date _____ Soc. Sec. # _____ Date Employed _____

Employer _____ Union/Local # _____ Work Phone _____

Empl. Address _____ City _____ State ____ ZIP _____

Primary Insurance Co. _____ Group # _____ ID # _____

Ins. Co. Address _____ City _____ State ____ ZIP _____

How much is your deductible? _____ How much used? _____ Max. Annual Benefit _____

DO YOU HAVE ADDITIONAL INSURANCE? YES ☐ NO ☐ IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship_____

Birth date _____ Soc. Sec. # _____ Date Employed _____

Employer _____ Union/Local # _____ Work Phone _____

Empl. Address _____ City _____ State ____ ZIP _____

Additional Insurance Co. _____ Group # _____ ID # _____

Ins. Co. Address _____ City _____ State ____ ZIP _____

How much is your deductible? _____ How much used? _____ Max. Annual Benefit _____

Patient Medical History:

Physician _____ Office Phone _____ Date of Last Exam _____

Are you under medical treatment now?	Yes	No
Have you been hospitalized for any reason within the last 5 years?	Yes	No
If so, please explain _____ _____		
Are you taking any medications, including Non-prescription medicines?	Yes	No
If so, what ones are you taking?_____ _____		
Have you ever taken Fen-Phen/Redux?	Yes	No
Do you use tobacco?	Yes	No
Do you use controlled substances?	Yes	No
Are you wearing contact lenses?	Yes	No
Women Only:		
Are you pregnant or think you may be pregnant? . .	Yes	No
Are you nursing?	Yes	No
Are you taking oral contraceptives?	Yes	No

To the best of your knowledge, have you ever had an allergic reaction or become ill on any of the following drugs:

Local Anesthetics (e.g. Novocaine).....	Yes	No
Penicillin or other Antibiotics.	Yes	No
Sulfa Drugs	Yes	No
Barbiturates	Yes	No
Sedatives	Yes	No
Iodine.....	Yes	No
Aspirin	Yes	No
Any metals (e.g. nickel, mercury, etc.)	Yes	No
Latex Rubber.....	Yes	No

Others (please list) _____ _____

10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?..... . .	Yes	No

Do You Have Or Have You Had Any Of The Following:

Patient No.: _____
(For office use only.

High Blood Pressure ----	Yes	No
Heart Attack ----	Yes	No
Rheumatic fever ---- .	Yes	No
Swollen Ankles ---- . .	Yes	No
Fainting / Seizures ---- . .	Yes	No
Asthma ---- . .	Yes	No
Low Blood Pressure ---- . .	Yes	No
Epilepsy / Convulsions --- . .	Yes	No
Leukemia ---- . .	Yes	No
Diabetes ---- . .	Yes	No
Kidney Diseases ---- . .	Yes	No
Aids or HIV Infection ---- . .	Yes	No
Thyroid Problems ---- . .	Yes	No

Heart Disease --- . .	Yes	No
Cardiac Pacemaker ---- . .	Yes	No
Heart Murmur ---- . .	Yes	No
Angina ---- . .	Yes	No
Frequently Tired ---- . .	Yes	No
Anemia ---- . .	Yes	No
Emphysema ---- . .	Yes	No
Cancer ---- . .	Yes	No
Arthritis ---- . .	Yes	No
Joint Replacement ---- . .	Yes	No
Hepatitis / Jaundice --- . .	Yes	No
STD's ---- . .	Yes	No
Stomach Ulcers ---- . .	Yes	No

Chest Pains ---- . .	Yes	No
Easily Winded ---- . .	Yes	No
Stroke ---- . .	Yes	No
Hay Fever / Allergies ---- . .	Yes	No
Tuberculosis ---- . .	Yes	No
Radiation Therapy ---- . .	Yes	No
Glaucoma ---- . .	Yes	No
Recent Weight Loss ---- . .	Yes	No
Liver Disease ---- . .	Yes	No
Heart Trouble ---- . .	Yes	No
Respiratory Problems ---- . .	Yes	No
Mitral Valve Prolapse ---- . .	Yes	No
Other ---- .	Yes	No

Patient Dental History:

Previous Dentist: _____ Phone No.: _____

Location: _____ Date Last Exam: _____

Do your gums bleed while brushing or flossing?	Yes	No
Are your teeth sensitive to hot or cold liquids/food?.....	Yes	No
Are your teeth sensitive to sweet or sour liquids/foods?	Yes	No
Do you feel pain to any of your teeth?.....	Yes	No
Do you have sores or lumps in or near your mouth?.....	Yes	No
Do you have any head, neck or jaw injuries?.....	Yes	No
Have ever experienced any of the following problems		
in your jaw:		
Clicking	Yes	No
Pain (Joint, ear, side of face).....	Yes	No
Difficulty in opening or closing	Yes	No
Difficulty in chewing	Yes	No

Do you have frequent headaches?	Yes	No
Do you clench or grind your teeth?	Yes	No
Do you bite your lips or cheeks frequently?	Yes	No
Have you ever had any difficult extractions		
in the past? .....Yes	No	
Have you ever had any prolonged bleeding		
following an extraction?	Yes	No
Have you had any orthodontic treatment?	Yes	No
Do you wear dentures or partials?	Yes	No
Have you ever received oral hygiene instructions		
regarding the care of your teeth and gums?	Yes	No
Do you like your smile?	Yes	No

Patient No.: _____
(For office use only.

Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my designated dependents.

X _____ **DATE:** _____

Signature of patient (or parent/guardian if minor)

Doctor's Comments:

_____

_____

_____

_____

_____

_____

_____

_____

X _____ **DATE:** _____

(Doctor's signature)

Patient No.: _____
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(Acknowledgement of)
Notice Of Privacy Practices

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I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health-care providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations, such as quality assessments and physician certification.

I acknowledge that a copy of **Notice of Privacy Practices** is available to me upon request, containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such **Notice of Privacy Practices** prior to signing this consent. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization anytime at the above address to obtain a current copy of such **Notice of Privacy Practices**.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health-care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ Relationship to Patient _____

Signature: _____

Date: _____

PATIENT AUTHORIZATION FORM

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be used or disclosed:

_____

_____

_____

_____

_____

Person or entity requesting the information and authorized to make the requested use or disclosure:

_____

Recipient of the information: _____

This information is being requested for the following purpose(s):

_____

_____

_____

_____

_____

This authorization shall remain in effect from the date signed below until

_____ (expiration date or event)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

☐ If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Patient Name: _____ Signature: _____

Relationship to Patient

(if signed by personal representative of Patient): _____ Date: _____