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.

Condition		
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

Condition		
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

Condition		
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: ____________

Question		
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

Question		
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:

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X ____ **DATE:** _______________

(Doctor's signature)

Patient No.: ____________
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(Acknowledgement of)

Notice Of Privacy Practices

Erieview Dental

General Dentists

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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: ___________________________