Confidential History for

_____

Please Print your Name

_____

Signature of Patient, Parent or Guardian

_____

Today's Date

Welcome to our office!

Complete information to the following questions will allow us to treat you on a more individual basis, providing the care appropriate for your particular needs. Some of the questions may seem personal of unrelated to dentistry, but knowledge of your overall health will help us tailor a dental plan specifically for you.
*Your answers are for **our records only** and will be considered **confidential.***
Thank you!

William R. Davidson, D.D.S., & Assoc.

Reviewed by: _____ Date:_____

Personal Information

Whom may we thank for referring you?_____

Mr. Mrs. Ms. Miss

Patient's Name_____Male_____Female_____
Last First Middle Nickname

Home Address_____
Street City State Zip

Home Phone (_____)_____ Social Security #_____Birth Date____/____/____
Cell/Pager/Fax Month Date Year

Employer Name_____Work Phone (____)_____-____ Other_____E-Mail_____
Area Code Ext. Cell/Pager/Fax

S/M/D/W Spouse_____ Employer_____ _____ Work Phone (___)_____
Marital Status Employer Address Area Code

If a child, name of parent or guardian:_____

Who is responsible for the account_____

Primary Dental Insurance Coverage

Subscriber Name_____Relation to Patient_____

Employer_____Address_____City_____State_____Zip_____

Work Phone (____)_____-_____Social Security #_____Birth Date_____/_____/_____

Insurance Co._____Address_____City_____State_____Zip_____

Group #_____Insurance Co. Phone (____)_____

Secondary Dental Insurance Coverage

Subscriber Name_____Relation to Patient_____

Employer_____Address_____City_____State_____Zip_____

Work Phone (____)_____-_____Social Security #_____Birth Date_____/_____/_____

Insurance Co._____Address_____City_____State_____Zip_____

Group #_____Insurance Co. Phone (____)_____

Medical Insurance Coverage

Subscriber Name_____Insurance Company_____

Group #_____Insurance Co. Phone (____)_____

Emergency Notification Information

In case of emergency, who should be notified? (Other than your spouse)

Name_____Address_____Phone (____)_____

INSURANCE RELEASE:
AUTHORIZATION TO PAY AND RELEASE INFORMATION: I hereby authorize insurance benefit payments directly to Dr. Davidson for his services. I am financially responsible for the charges not covered. A copy of this authorization shall be as valid as the original. I also authorize William R. Davidson, D.D.S., Inc. to release to the insurance company any information acquired in the course of examination or treatment relating to my insurance claim.

To the best of my knowledge, all of these answers are true and correct. I understand this information will be kept confidential. I will inform your office of any changes.

_____

Signature of Patient, Parent or Guardian Date

Personal Medical History

- Your age_____
- Are you under a physician's care for any reason? **Yes** **No**
- If yes, for:_____
- Are you currently taking any medications that have been prescribed by a physician? **Yes** **No**

Medicine:_____ for:_____

Medicine:_____ for:_____

Medicine:_____ for:_____

- Have you been hospitalized for any serious illness or surgery in the past 5 years? **Yes** **No**

If **yes**, for:_____

- Do you require **pre-medication** for dental treatment? **Yes** **No**

Are you *allergic* (get hives, rash, itching) to any of these drugs (Circle Yes or No):

Aspirin	**Yes**	**No**	Ibuprofen (Advil, Motrin, Nuprin)	**Yes**	**No**	Penicillin	**Yes**	**No**
Codeine	**Yes**	**No**	Latex (as in medical gloves)	**Yes**	**No**	Sulfa	**Yes**	**No**
Erythromycin	**Yes**	**No**	Metals	**Yes**	**No**			

Other Allergies:_____

Have you had or do you now have any of the following (Circle Yes or No):

Alcohol/Chemical Dependency	**Yes**	**No**	Fainting Spells	**Yes**	**No**	Pace Maker	**Yes**	**No**
Allergies	**Yes**	**No**	HIV+ or AIDS	**Yes**	**No**	Psychiatric Treatment	**Yes**	**No**
Anemia	**Yes**	**No**	Heart Murmur	**Yes**	**No**	Radiation	**Yes**	**No**
Arthritis	**Yes**	**No**	Heart Trouble	**Yes**	**No**	Rheumatic Fever	**Yes**	**No**
Asthma	**Yes**	**No**	Hepatitis	**Yes**	**No**	Sexually Transmitted Disease	**Yes**	**No**
Bleeding/Clotting problems	**Yes**	**No**	High Blood Pressure	**Yes**	**No**	Sinus Problems	**Yes**	**No**
Cancer	**Yes**	**No**	Implants	**Yes**	**No**	Sjrogrens Syndrome	**Yes**	**No**
Chemotherapy	**Yes**	**No**	Joint Replacement	**Yes**	**No**	Steroids	**Yes**	**No**
Cholesterol	**Yes**	**No**	Kidney Problems	**Yes**	**No**	Stomach Ulcers	**Yes**	**No**
Diabetes	**Yes**	**No**	Liver Problems	**Yes**	**No**	Transplants	**Yes**	**No**
Emphysema	**Yes**	**No**	Lupus	**Yes**	**No**	Tuberculosis	**Yes**	**No**
Epilepsy	**Yes**	**No**	Mitral Valve Prolapse	**Yes**	**No**			

- Have you had any other serious illnesses or diseases? **Yes** **No**

If yes, _____

Do you use tobacco products? **Yes** **No**

If female:

- Are you taking birth control pills? **Yes** **No**
- Are you pregnant or nursing? (If Pregnant how many weeks _____) **Yes** **No**
- Are you having any problems with your menstrual cycle? **Yes** **No**

Please list your physician(s)

Name:_____Specialty:_____Phone:_____

Personal Dental History

- Are you having any discomfort or concerns with your teeth or mouth at this time? **Yes** **No**

  If yes, for:_____

- Have you ever had any serious trouble associated with previous dentistry? **Yes** **No**
- Date of last dental visit_____
- Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? **Yes** **No**
- How often do you brush?_____How often do you floss?_____
- Do you have or have you ever had any of the following?

MOUTH			TEETH		
Bleeding, sore gums	**Yes**	**No**	Loose teeth	**Yes**	**No**
Unpleasant taste/bad breath	**Yes**	**No**	Sensitive to hot	**Yes**	**No**
Burning tongue/lips	**Yes**	**No**	Sensitive to cold	**Yes**	**No**
Frequent blister, lips/mouth	**Yes**	**No**	Sensitive to sweets	**Yes**	**No**
Swelling/lumps in mouth	**Yes**	**No**	Sensitive to biting	**Yes**	**No**
Ortho treatments (braces)	**Yes**	**No**	Food trapping in teeth	**Yes**	**No**
Biting cheeks/lips	**Yes**	**No**	Clenching/grinding	**Yes**	**No**
Clicking/popping jaw	**Yes**	**No**	If so, when_____		
Difficulty opening or closing jaw	**Yes**	**No**	Change in bite	**Yes**	**No**
Dry mouth	**Yes**	**No**			
Frequent cold sores/herpes	**Yes**	**No**			

- Do you use a mouthwash? **Yes** **No** If **yes**, what brand?_____
- Have you noticed any recent wrinkling around your mouth/face? **Yes** **No**
- Have you noticed any "sinking" around your cheeks? **Yes** **No**
- Do you enjoy chewing your food? **Yes** **No**

  If no, what is the reason?_____
- Do you find that you are developing space between your teeth? **Yes** **No**
- Do you have any particular fears or other concerns about dental treatments?_____

_____

- My mouth is: **Comfortable** **Uncomfortable**
- I am satisfied with the appearance of my mouth **Yes** **No**
- I think my present state of dental health is:

  Very Good **Good** **Fair** **Poor**
- What are some questions about dentistry and oral health that you have never had adequately answered?

_____

_____

William R. Davidson, D.D.S., Inc.

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)

_____

_____

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

William R. Davidson, D.D.S., Inc.

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 (04/13/03), 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 at any time. For more information about our 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).

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 copies, we will charge you $0.75 for each page, $25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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.

WILLIAM R. DAVIDSON, D.D.S. & ASSOCIATE
9365 Olde Eight Road
Northfield, OH 44067
(330) 467-6066

Thank you for choosing Dr. Davidson as your dentist. Along with excellent health care, financial matters need to be considered. Please read and sign the following financial agreement.

Usually, payment for services is due at the time they are provided. It is quite possible to arrange a payment schedule. For payment options, please see the Financial Menu below.

FINANCIAL MENU

A. Prepay Courtesy
A prepayment courtesy of 5% will be subtracted from the total* patient *obligation (not from any portion due from insurance company) if the patient obligation is paid in full at the first treatment visit.

B. American General (for fees over $250.00)
With fast approval via fax from American General, your payments can be much lower than those available through our office. American General is based in Ohio and specializes exclusively in helping patients with larger dental cases to do the treatment they want. AG carries no interest whatsoever for balances financed for a period ranging from six months to 12 months. We will assist you in processing your application.

C. Three Payments (for fees over $1000)
Total patient obligation may be divided as follows: 50% due at the first treatment visit, with the remaining balance split into two equal payments, due 30 and 60 days after the first treatment visit. For any fees under $1000, the full amount is due at the initiation of any procedure. Note: balance payments will be written at the initiation of treatment, "post-dated" for 30 and 60 days – our guarantee: If a post-dated payment is deposited prior to the date on the check (or credit card slip) we will credit your account for an amount equal and in addition to that payment.

D. Pay as You Go. You may choose to pay your obligation for each visit, at the visit.

FORMS of PAYMENT and BALANCES DUE

In order to facilitate access to the very best health care possible, you may choose from any of the following (including any combination thereof): Cash, Visa, MasterCard, American Express, Discover, Money Order, Personal Checks, or American General (see above).
Balance over 60 days will incur a finance charge of 18% APR.

INSURANCE

It is our pleasure to assist you in maximizing your insurance benefit by completing your claim forms. If your carrier is up to date (in over 70% of the cases), the claims will be transmitted via computer modem before the end of the treatment day! As a courtesy, in addition to filing the claim, if you prefer we will initially ask you only for your estimated copayment. Please understand that this is only an estimate, and is based upon the information available to us.

The range of benefits depends solely on what your employer wishes to purchase. Some plans cover as little as 30% or as much as 100% of dental services, with most falling in the 40% to 80% range.

Some plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies. For this reason, you may receive a lower percentage than the reimbursement level indicated in your dental plan. For example, if your plan states that it will pay 80% of the cost of a specific treatment, it means 80% of the fee arbitrarily determined by the insurance company and not the actual fee charged by our office.

The financial obligation for dental treatment is between you and our office. Your insurance is a contract between you, your employer and the insurance company. We are not a part of that contract. We will assist you in any way that we can by filing your claims and working to obtain your maximum available benefits. Once your carrier has paid the claim, any difference will be due upon receipt of our statement. If for any reason, we have not received your insurance carrier's payment 90 days after the claim, the remaining balance will be due and payable by you, and subject to 18% APR.

If you have any questions concerning the above information or are uncertain regarding insurance information, please do not hesitate to ask!

"I have read all of the above information and I understand and agree that (regardless of my insurance), I am ultimately responsible for the balance on my account for any professional services rendered."

_____

NAME (please print) ----------

SIGNATURE ---------- DATE ----------