PATIENT REGISTRATION

PATIENT INFORMATION

First Name: _____Last Name: _____Middle Initial:_____

Address:_____City:_____State:_____ Zip Code:_____

Home Phone: _____ Cell Phone: _____Work Phone: _____Ext:_____

Birthdate: _____ Social Security Number: _____ Email:_____

Sex: ___MALE___FEMALE Marital Status: ___MARRIED ___SINGLE ___DIVORCED ___SEPARATED ___WIDOWED

Employer: _____Occupation: _____

Previous Dentist: _____

Emergency Contact: _____Relationship:_____

Emergency Contact Phone Number: _____ Referred by: _____

RESPONSIBLE PARTY

First Name: _____ Last Name: _____Middle Initial: _____

Relationship to patient: _____

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

Home Phone: _____ Cell Phone: _____ Work Phone: _____Ext: _____

Birthdate: _____ Social Security Number: _____ Email: _____

Employer: _____ Occupation: _____

PRIMARY INSURANCE INFORMATION

Dental Insurance Company: _____

ID Number/ Member ID: _____

Insurance Co. Address:_____

Policyholder Name: _____

Policyholder SSN: _____

Policyholder Employer: _____

Policyholder Birthdate: _____

SECONDARY INSURANCE INFORMATION

Dental Insurance Company: _____

ID Number/ Member ID: _____

Insurance Co. Address: _____

Policyholder Name: _____

Policyholder SSN: _____

Policyholder Employer: _____

Policyholder Birthdate: _____

I have read and understand the Notice of Privacy Practices and Authorization (HIPPA).

Signature: _____Date:_____

Relationship to Patient: _____

I give my consent to Kohler Dental Associates to notify/contact me via encrypted email or text which may include personal health information. (ie. appointment reminders, notifications)

Signature: _____Date: _____

Relationship to patient:_____

DENTAL HISTORY

Patient Name:_____**Birthdate:**_____

How would you rate the condition of your mouth? Excellent Good Fair Poor
Previous Dentist:_____ How long have you been a patient?_____
Date of most recent dental exam:_____ Date of most recent x-rays:_____
Date of most recent treatment (other than cleaning):_____
I routinely see the dentist every: 3 months 4 months 6 months 12 months Not routinely
What is your immediate concern?_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
PERSONAL HISTORY		
Have you had an unfavorable dental experience?	___	___
Have you had complications from past dental treatment?	___	___
Have you ever had trouble getting numb or had reactions to local anesthetic?	___	___
Did you ever have braces, orthodontic treatment, or have your bite adjusted?	___	___
Have you had any teeth removed?	___	___
Do you use fluoride toothpaste or supplements?	___	___
SMILE CHARACTERISTIC		
Is there anything about the appearance of your teeth you would like to change?	___	___
Have you ever whitened (bleached) your teeth?	___	___
Have you felt uncomfortable or self-conscious about the appearance of your teeth?	___	___
Have you been disappointed with the appearance of previous dental work?	___	___
BITE AND JAW JOINT		
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	___	___
Do you/would you have any problems chewing gum?	___	___
Do you/would you have any problems chewing hard foods?	___	___
Have your teeth changed in the last 5 years, become thinner, shorter, or worn?	___	___
Do you chew ice, bite your nails, use your teeth to hold objects, or other oral habits?	___	___
Do you clench your teeth in the daytime or do they become sore?	___	___
Do you have any problems with sleep or wake up with awareness of your teeth?	___	___
Do you wear or have you ever worn a bite appliance?	___	___
TOOTH STRUCTURE		
Have you had any cavities within the past 3 years?	___	___
Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing food?	___	___
Do you feel or notice any holes (ie. pitting, craters) on the biting surfaces of your teeth?	___	___
Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	___	___
Do you have any grooves or notches on your teeth near the gumline?	___	___
Have you ever had broken teeth, chipped teeth, or had a toothache or cracked filling?	___	___
Do you frequently get food caught between any teeth?	___	___
BIOLOGY		
Do your gums bleed or are they painful when brushing or flossing?	___	___
Have you ever been treated for gum disease or been told you lost bone around your teeth?	___	___
Have you ever noticed an unpleasant odor in your mouth?	___	___
Is there anyone with a history of periodontal disease in your family?	___	___
Have you ever noticed gum recession?	___	___
Have you ever had any teeth become loose on their own (no injury)?	___	___
Have you experienced a burning sensation in your mouth?	___	___

MEDICAL HISTORY

Patient Name:_____ **Birthdate:**_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

IF YOU ANSWER YES TO ANY OF THE FOLLOWING QUESTIONS, PLEASE EXPLAIN IN THE SPACE PROVIDED:

	YES	NO
Are you under a physician's care now? _____	___	___
Have you ever been hospitalized or had a major operation? _____	___	___
Do you take any blood thinners or antiplatelet medications? _____	___	___
Are you taking any medications, pills, or drugs? _____	___	___
If yes, please provide a MED LIST: _____		
Do you take, or have you taken Phen-Fen or Redux? _____	___	___
Do you take any medication for osteoporosis (i.e. Fosamax)_____	___	___
Have you had a total or partial joint replacement? i.e. knee, hip, or shoulder? _____	___	___
Do you use tobacco? _____	___	___
Do you use controlled substances? _____	___	___

*__WOMEN__, are you: (circle all that apply) Pregnant Trying to get pregnant Taking oral contraceptives Nursing

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

___Aspirin ___Penicillin ___Codeine ___Local Anesthetics ___Acrylic ___Metal ___Latex
___Sulfa Drugs ___Erythromycin ___Other If yes, please explain:_____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

	YES NO		YES NO		YES NO		YES NO
AIDS/HIV positive	___ ___	Emphysema	___ ___	Irregular Heartbeat	___ ___	Thyroid Disease	___ ___
Alzheimer's Disease	___ ___	Epilepsy or Seizures	___ ___	Kidney Problems	___ ___	Tuberculosis	___ ___
Anaphylaxis	___ ___	Excessive Bleeding	___ ___	Leukemia	__ ___	Tumors/Growths	___ ___
Anemia	___ ___	Excessive Thirst	___ ___	Liver Disease	___ ___	Ulcers	___ ___
Angina	___ ___	Fainting Spells/Dizziness	___ ___	Low Blood Pressure	___ ___	Venereal Disease	___ ___
Arthritis/Gout	___ ___	Frequent Cough	___ ___	Lung Disease	___ ___	Yellow Jaundice	___ ___
Artificial Heart Valve	___ ___	Frequent Diarrhea	___ ___	Mitral Valve Prolapse	___ ___		
Artificial Joint	___ ___	Frequent Headaches	___ ___	Osteoporosis	___ ___		
Asthma	___ ___	Genital Herpes	___ ___	Pain in Jaw Joints	___ ___		
Blood Disease	___ ___	Glaucoma	___ ___	Parathyroid Disease	___ ___		
Blood Transfusion	___ ___	Hay Fever	___ ___	Psychiatric Care	___ ___	**Have you had any serious illness**	
Breathing Problem	___ ___	Heart Attack/ Failure	___ ___	Radiation Treatment	___ ___	**not listed above?**_____	
Bruise Easily	___ ___	Heart Murmur	___ ___	Recent Weight Loss	___ ___	_____	
Cancer	___ ___	Heart Pacemaker	___ ___	Renal Dialysis	___ ___	_____	
Chemotherapy	___ ___	Heart Trouble/ Disease	___ ___	Rheumatic Fever	___ ___	_____	
Chest Pains	___ ___	Hemophilia	___ ___	Rheumatism	___ ___	_____	
Cold Sores	___ ___	Hepatitis A	___ ___	Scarlet Fever	___ ___	_____	
Congenital Heart Disorder	___ ___	Hepatitis B or C	___ ___	Shingles	___ ___	_____	
Convulsions	___ ___	Herpes	___ ___	Sickle Cell Disease	___ ___	_____	
Cortisone Medicine	___ ___	High Blood Pressure	___ ___	Sinus Trouble	___ ___	**Comments:**_____	
Diabetes	___ ___	High Cholesterol	___ ___	Stomach Problems	___ ___	_____	
Drug Addiction	___ ___	Hives or Rash	___ ___	Stroke	___ ___	_____	
Easily Winded	___ ___	Hypoglycemia	___ ___	Swelling of Limbs	___ ___	_____	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent, or Guardian_____ **Date:**_____

KOHLER DENTAL ASSOCIATES · 16620 ST RT 267 · EAST LIVERPOOL OH 43920 · 330-385-1198 · info@kohlerdental.com

FINANCIAL POLICY

THIS AGREEMENT IS TO INFORM YOU OF YOUR FINANCIAL OBLIGATION TO OUR PRACTICE. THIS FINANCIAL AGREEMENT IS INTENDED TO FACILITATE OUR ABILITY TO PROVIDE EXCELLENT SERVICE TO YOU WHILE MINIMIZING OUR ADMINISTRATIVE COSTS.

INSURANCE

As a courtesy to you, we will help process all your insurance claims. For our practice to file your insurance claim, you must provide proof of insurance either with a card or information provided to the office when setting up the appointment. ***All charges you incur are your responsibility regardless of your insurance coverage.***

PAYMENT DUE AT TIME OF SERVICE

Payments are expected at the time of service. Your estimated co-payment for treatment, which is the amount not covered by insurance, is due at the time treatment is provided. Your estimated co-payment may be adjusted after the time of treatment depending on the final reconciliation of insurance payments. If you do not have insurance, we expect full payment for service at each office visit.

We accept these forms of payment: **CASH · CHECK · MASTERCARD · VISA · DISCOVER · AMERICAN EXPRESS · CARE CREDIT**

PAYMENT PLANS

Our office can offer a three-month payment plan option. You are eligible for a payment plan if you are a patient on record, have shown good credit, and if your total balance exceeds $500. Our policy for a payment plan is to only accept post-dated checks or a valid credit card number to draw on a specified day of each month. The checks or card information must be given the time of service. If your treatment exceeds the cost of $1000, fifty percent will be the expected payment at the time service. The remaining balance can then be processed on a payment plan.

INTEREST

Returned checks and balances older than 90 days will be subject to collection fees and charges at the rate of 1.5% per month.

APPOINTMENT POLICY

I understand the cancellation policy which states, “Reserved times cancelled within 48 hours are subject to a $50 cancellation fee.” An appointment cancelled within 48 hours limits our ability to fill the time with a patient in need. We appreciate your understanding and working with us to avoid this scenario.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care but need your financial commitment as well.

Print name of patient or responsible party_____

Signature of patient or responsible party_____**Date**_____

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Notice of Privacy Policy

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 Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health providers keep your medical and dental information private. The HIPAA Privacy Rule states that health providers must also post in a clear and prominent location, and provide patients with, a written Notice of Privacy Policy.

The privacy practices described are currently in effect. We reserve the right to change our privacy practices, and the terms of this Notice at any time, provided such changes are permitted by law. If changes are made, a new Notice of Privacy policy will be displayed in our office and provided to patients. You may request a copy of our Notice at any time. Additional information may be obtained from the HIPAA Coordinator listed in our written HIPAA plan.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following describes how information about you may be used in this dental office:

- **Treatment Services:** We may use or disclose your health information to all of our staff members, other dentists, your physicians, and/or other health care providers taking care of you.
- **Payment and Health Care Operations:** We may use or disclose your health information to obtain payment for services we provide to you, to participate in quality assurance, disease management, training, licensing, and certification programs. Upon your written request, we will not disclose to your health insurer any services paid by you out of pocket.
- **Marketing/Fundraising:** We will not use your health information for marketing or fundraising purposes without your written consent. You can opt out of receiving information about our marketing or fundraisers. We will not sell your health information without your explicit authorization.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, text messages, emails, postcards, or letters.
- **Legal Requirements:** We may use or disclose your health information when required to do so by law.
- **Abuse or Neglect:** If abuse or neglect is reasonably suspected, we may use or disclose your health information to the appropriate governmental authorities.
- **National Security:** When required, we may disclose military personnel health information to the Armed Forces. Information may be given to authorized federal offices when required for intelligence and national security activities. Health information for inmates in custody of law enforcement may be provided to correctional institutes.
- **Family Members, Friends, and Others Involved in Care:** At your request, we may disclose your health information to a family member or other person if necessary, to assist with your treatment and/or payment for services. Based on our judgement and as per 164.522(a) of HIPAA we may disclose your information to these persons in the event of an emergency. We also may make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays for you. Your information may be disclosed to assist in notifying a family member, caregiver, or personal representative of your location, condition, or death.
- **Business Associates:** Some services in our organization are provided through contacts with business associates. Examples include practice management software representatives, accountants, answering service personnel, etc. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. All our business associates are required to safeguard your information and to follow HIPAA Privacy Rules.
- **Workers' Compensation:** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.
- **Research:** We may use or disclose medical information to researchers when an institution's review board or special privacy board has reviewed the proposed study and established protocols to ensure the privacy of the health information used in their research and determined that the researcher does not need to obtain your authorization prior to using your medical information for research purposes.
- **Public Health Activities:** We may use or disclose your health information for public health activities, to include the following: to prevent or control disease, injury, or disability; to report reactions with medications or problems with products, to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or who may be at risk for

contracting or spreading a disease of condition; to notify the proper government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (when required by law).

- **Other Authorizations:** 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 authorization, you may revoke it 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.
- **Breach Notification:** We will notify you any time your PHI may have been compromised through unauthorized acquisition, use or disclosure.

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.
  We will charge you a reasonable cost-based fee for expenses such as copies. If you request X-Rays, there will be a fee for any copies of films. You are not entitled to originals, only copies. Postage will be added if copies are to be mailed. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Details of all fees are available from the HIPAA Coordinator.
- **Accounting of Disclosures:** 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. 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 will keep your information confidential from your health plans if you pay cash, at your request. In some instances, we may not be 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 must explain the reason for the amendment.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our Privacy Policy or have questions or concerns, please contact us. If you have concerns relating to a perceived violation of your privacy rights, to access to your health information, to amending or restricting the use or disclosure of your health information, or to requesting alternative means of communication, you may contact us using the contact information listed at the end of this Notice. You also may submit a written complaint to the Department of Health and Human Services (HHS). We will provide you with the HHS address 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 HHS.

Contact Officer: Dr. Jonathan Kohler

Telephone: 330-385-1198 Fax: 330-385-7230

Email: info@kohlerdental.com

Address: 16620 St Rt 267 East Liverpool, OH 43920