Dublin Reserve
DENTAL GROUP

CONROY • GESTOSANI • TIEMSTRA
6790 Perimeter Drive, Suite 100
Dublin, OH 43016
614-717-3500 • 614-717-0933 (fax)
www.dublinreservedental.com

Welcome to our office! In order to get to know you better and to give you the most consideration of your time, please complete both sides of this form. All information is, of course, confidential.

Last Name: ______________________ First Name: ______________________ M.I. _____

Preferred First Name: ______________ Date of Birth: __________ Social Security No.: ______________

Address: ______________________________ City: ______________ State: ________

Zip: __________ E-Mail Address :______________________________________

Cellular Telephone: ______________________ Work Telephone: ______________________

Employer: ______________________ Occupation: ______________________

☐ Male ☐ Female ☐ Minor Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed

PERSON RESPONSIBLE FOR ACCOUNT

Relationship to patient: ______________________

Last Name: ______________________ First Name: ______________________ M.I. _____

Address: ______________________________ City: ______________ State: ________

Zip: ________ Home Telephone: ______________ Work/Mobile Telephone: ______________

Date of Birth: __________ Social Security No. : ______________ E-Mail: ______________

Employer: ______________________ Occupation: ______________________

Spouse's Name: ______________________________ Date of Birth: ______________

Social Security No. : ______________________ E-Mail: ______________________

Employer: ______________________ Occupation: ______________________

PRIMARY DENTAL INSURANCE: ☐ Yes ☐ No

Policy Holder: ______________________

Insurance Company: ______________________

Subscriber ID: ______________________

Group Number: ______________________

SECONDARY INSURANCE: ☐ Yes ☐ No

Policy Holder: ______________________

Insurance Company: ______________________

Subscriber ID: ______________________

Group Number: ______________________

EMERGENCY CONTACT INFORMATION

In case of an emergency whom should contact: ______________________________

Relationship to patient: ______________________ Telephone Number: ______________________

HOW DID YOU LEARN ABOUT OUR PRACTICE?______________________________

Please complete the Health History on the reverse of this page

HEALTH HISTORY for Patient: ___________________________________

Are you aware of any particular dental problems? ____________________ Are you having any discomfort or pain? ___________________________

How long has it been since you last visited a dental office? ________________ Who was your previous dentist? ___________________________

May we ask why you left? ____

Has any dental treatment ever been recommended that hasn't been done? □ Yes □ No

How do you feel about having dental work done? □ DREAD IT □ WORRY ABOUT IT □ DON'T MIND

If you could change your smile, how would you want it to look? ____

Your physician's name: ____

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 medications that you may be taking, could have an important interrelationship with the dental treatment you receive. Thank you for answering the following questions.

Are you under a physician's care now? □ Yes □ No □ N/A ____

Have you ever been hospitalized or had a major operation? □ Yes □ No □ N/A ____

Have you ever had a serious head or neck injury? □ Yes □ No □ N/A ____

Are you taking any medication, pills or drugs? □ Yes □ No **IF YES PLEASE LIST THEM IN THE COMMENTS SECTION BELOW**

Do you take, or have you taken, Phen-Fen or Redux? □ Yes □ No

Have you ever taken Fosamax, Boniva, Actonel □ Yes □ No
or any other medications containing bisphosphonates?

Are you on a special diet? □ Yes □ No

Do you use tobacco? □ Yes □ No

Do you use controlled substances? □ Yes □ No

Women: Are you □ Pregnant □Nursing
□ Taking oral contraceptives

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other ________________________

Do you have, or have you had, any of the following?

□ AIDS/HIV
□ Alzheimer's Disease
□ Anaphylaxis
□ Anemia
□ Angina
□ Arthritis/Gout
□ Artificial Heart Valve*
□ Artificial Joint*
□ Asthma
□ Blood Disease
□ Blood Transfusion
□ Breathing Problems
□ Bruise Easily
□ Cancer
□ Chemotherapy
□ Chest Pains
□ Cold Sores/Fever Blisters
□ Congenital Heart Disorder
□ Convulsions
□ Cortisone Medicine
□ Diabetes
□ Drug Addiction
□ Easily Winded
□ Emphysema
□ Epilepsy or Seizures
□ Excessive Bleeding
□ Excessive Thirst
□ Fainting Spells/Dizziness
□ Frequent Cough
□ Frequent Diarrhea
□ Frequent Headaches
□ Glaucoma
□ Hay Fever
□ Heart Attack/Failure
□ Heart Murmur*
□ Heart Pace Maker*
□ Heart Trouble/Disease
□ Hemophilia
□ Hepatitis A
□ Hepatitis B or C
□ Herpes
□ High Blood Pressure
□ High Cholesterol
□ Hives or Rash
□ Hypoglycemia
□ Irregular Heartbeat
□ Kidney Problems
□ Leukemia
□ Liver Disease
□ Low Blood Pressure
□ Lung Disease
□ Mitral Valve Prolapse*
□ Osteoporosis
□ Pain in Jaw Joints
□ Parathyroid Disease
□ Psychiatric Care
□ Radiation Treatment
□ Recent Weight Loss
□ Renal Dialysis
□ Rheumatic Fever*
□ Rheumatism
□ Scarlet Fever
□ Shingles
□ Sickle Cell Disease
□ Sinus Trouble
□ Spina Bifida
□ Stomach/Intestinal Disease
□ Stroke
□ Swelling of Limbs
□ Thyroid Disease
□ Tonsillitis
□ Tuberculosis
□ Tumors or Growths
□ Ulcers
□ Venereal Disease
□ Yellow Jaundice

* Condition may require pre-medication N/A – not answered by patient

Have you ever had any condition not listed above? □ Yes □ No □ N/A ____

Comments: ____

____

____

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

____

Signature of patient, parent or guardian Date

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HIPAA CONSENT

☐ I give permission to the doctors and staff of Dublin Reserve Dental Group, Ltd. to leave voicemail messages, text messages, and e-mails concerning my appointments and any appointments for my dependent children. I understand it is my responsibility to inform the office of any changes in this information. Please leave information at the following phone numbers and address:

______________________________ cell home work other

______________________________ cell home work other

______________________________ cell home work other

Home address: ____

City: ______________________ State: __________ Zip: ______________

Text messages (optional for reminders) ______________________________

E-mail (optional for reminders) ___________________________________

Child(ren)'s or ward(s) name(s) is/are: ______________________________

____

____

____

____

☐ I give permission to Dublin Reserve Dental Group, Ltd. to discuss my treatment, charges and all necessary information related to my care with the following person (consent may be revoked at any time per the patient's request in writing).

Name(s): ____

☐ I also acknowledge that I have received a copy of and understand the HIPAA Privacy Policy for Dublin Reserve Dental Group.

____
Patient, Parent or Guardian Signature

____
Relationship to patient

____
Date

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CONSENT FOR TREATMENT
INSURANCE RELEASE/AUTHORIZATION

I give my permission for the dentists and staff of Dublin Reserve Dental Group to treat me, including any procedure(s) as deemed necessary in the exercise of their professional judgment. Please check or initial each item.

_____ I understand that dental care requires my cooperation, and I will follow my dentist's recommendations and prescriptions. If indicated, I will make and keep appointments for follow-up care and call the office to note any changes or concerns in my condition.

_____ I authorize my dentist and Dublin Reserve Dental Group to use photography/video tape or other similar means to record my procedure(s). I understand that reproduction or publication of said photographs and recordings will be used for the purpose of insurance predeterminations, patient education, before and after dental portfolios and/or documentation for my dental record and require an additional consent/release for any publication.

_____ I further acknowledge that all recorded media obtained is the sole property of Dublin Reserve Dental Group. All x-rays photos, etc. are to be maintained by Dublin Reserve Dental Group, as required by law. Patients are entitled to copies of any/all patient materials.

_____ I hereby certify that I have read the foregoing CONSENT and fully understand the contents thereof.

Patient Name: (Print) ____Date:_______________

Patient/Parent or Guardian's Signature:____

Dublin Reserve Dental Witness: ____Date:_______________

AUTHORIZATION AND RELEASE

_____ I have read and understand the consent forms that have been provided to me by the dentists and staff of Dublin Reserve Dental Group.

_____ I authorize my dentist to release any information, including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers.

_____ I authorize and request that my insurance company, in lieu of reimbursing me directly, pay to the dentist or dental group any benefits for services rendered.

_____ I understand that my dental insurance carrier may pay less than the actual bill for services. I agree that I may be responsible for payment of all services rendered on my behalf or my dependents.

_____ I have received, read and fully understand the financial policy and payment options for Dublin Reserve Dental Group.

____ ____________________

Signature of Patient or Parent (if Minor) Date

FINANCIAL POLICY FOR DUBLIN RESERVE DENTAL GROUP

The dentists at Dublin Reserve Dental Group are in-network providers for the following insurance plans:

Aetna PPO (Aetna Dental Admin / Sunlife)
Anthem (Complete, Prime, Grid Plus, Traditional PPO)
Assurant / Fortis / DHA
Cigna PPO
Connection / GEHA / 32Dental / Ametitas / Reliance Standard / Principal / Lincoln
Delta Dental DPO/PPO
Delta Premier
Guardian / Dental Guard / Jefferson Pilot / Fiserv
Metlife PDP
Liberty Dental
Humana (NOT ACCEPTED: Federal Humana, Humana Advantage, Humana DMO/DHMO plans)

We also accept any traditional indemnity plans, which allow their subscribers complete freedom of choice of providers.

We do not accept DMO or HMO dental plans. If you have signed up for either of these plans, you have been assigned a primary care dentist or you will have to choose from a list of DMO/HMO providers. Any services performed for patients with DMO or HMO dental plans are not covered in our office and will be the responsibility of the patient.

We routinely file claims and accept insurance payments as a courtesy to our patients. Please note that some plans have yearly maximums, deductibles, waiting periods, limitations, alternate benefits, and missing tooth clauses that may limit your benefits. Our staff does its best to obtain as much information about your plan from the insurance company, but you are ultimately responsible for knowing your coverage. Consult the carrier, your HR person, or your benefit plan book for more information regarding your plan.

UNDERSTANDING INSURANCE

We understand insurance can be very confusing. We are happy to assist in maximizing your dental benefits, but your insurance plan is a contract between you, your employer, and the insurance carrier.

This is where the confusion may begin. Some patients believe that the filing, tracking, and collection for their insurance rests solely on the medical or dental office. The ADA, AMA, your HR representative, and even your insurance carrier will confirm this is ***your*** insurance policy and you are the responsible party. To help minimize confusion and assist as much as possible, we do submit pre-determinations of benefits, and we can check by phone and/or website to verify and gain information for you. We suggest that you research this information on your own and know your insurance plan and the benefits it provides. Your HR department is your best source of information.

PROTOCOL AND POLICIES

We ask that you provide accurate insurance information prior to or at the time of arrival for your appointment. We will file your claim at our expense as a courtesy. We will try to obtain as much information about your plan as the carrier will allow. After 30 days have elapsed, we will research and re-file your claim if necessary. At 30 to 45 days, we will send you a letter informing you of any problems and ask that you become involved with your insurance company. At 60 days we ask that you satisfy the balance if no payment has been made by the insurance company. We will re-file or appeal without any expense to you, and direct the monies to you since you have met your obligation to us. In the unfortunate event any account reaches 90 days we will attempt to provide you a final notice. On the 97th day we will reluctantly forward this to an outside collection agency. ***Patients will be charged up to 50% of the collection agency fee should the account(s) be sent to a third-party agency for the purpose of collecting any outstanding debt over 90 days.***

Patient co-payments are due on the day services are rendered to help control costs associated with billing and collections and to comply with contractual provisions of multiple insurance carriers. For these co-payments we accept the following forms of payment: Cash, Check, Mastercard, Visa, American Express, Discover, and interest free payment plans up to 6 months through Card Credit Finance (applications available at front desk).

REMINDER: Broken/missed appointments, late arrivals (more than 15 minutes after your scheduled appointment), and appointments canceled with less than 24 hours notice may be charged $40 per hygiene appointment and $80.00 per hour per doctor appointment. If you are unable to keep your appointment, please notify our office **at least 24 hours** in advance by calling 614-717-3500.

____________________________________ ______________

Patient Signature (or guardian) Date

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HIPAA Privacy Policy

This notice describes how personal health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

It is the policy of our practice that the dentist and staff preserve the integrity and confidentiality of **P**rotected **H**ealth **I**nformation **(PHI)** pertaining to our patients. The purpose of this policy is to ensure that our practice and its dentists and staff have the necessary medical and PHI to provide the highest quality dental care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its dentists and staff for the purpose of **T**reatment, **P**ayment and dental **O**perations **(TPO)**. To that end, our practice, its dentists and staff will:

1. Adhere to the standards set forth in the Notice of Privacy Practices.

2. Collect, use and disclose, PHI only in conformance with state and federal laws, and current covenants and/or authorization from the patient (or parent/guardian).

3. Remind patients of their appointments and file insurance on their behalf unless they instruct us not to do so.

4. Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice, its dentists and staff will:

    a. Implement reasonable measures to protect the integrity of all PHI maintained about patients.

5. Recognize that patients have a right to privacy. Our practice and its dentists and staff respect the patient's individual dignity at all times. Our practice and its dentists and staff will respect the patient's privacy to the extent consistent with providing the highest quality dental care possible and with the efficient administration of the facility.

6. Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its dentists and staff will:

    a. Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
    b. Not disclose PHI data unless the patient (or his/her authorized representative has properly authorized the release, or the release is otherwise authorized by law.

7. Recognize that, although our practice "owns" the dental records, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her dental record if he/she believes his/her is inaccurate or incomplete. Our dentists and staff will:

    a. Permit patients access to their dental records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site dental professional review the patient's appeal.
    b. Provide patients an opportunity to request the corrections of inaccurate or incomplete PHI in their dental records in accordance with the law and professional standards.

8. The dentists and staff of our practice will maintain a list of certain disclosures of PHI for the purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rule. We will provide this list to patients upon request, so long as their requests are in writing.

9. The dentists and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that our patients have requested and have been approved by our practice.

10. The dentists and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

11. The dentists and staff of our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

______________________________________ ____________

Patient Signature (or guardian) Date

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BROKEN APPOINTMENT POLICY

Your appointment time has been reserved especially for you. If you are unable to keep your appointment, please notify our office **at least 24 hours** in advance. Our primary goal is patient care, and as a courtesy our staff will ***attempt*** to confirm your appointment, but it is the patient (or guardian's) sole responsibility to confirm and keep scheduled appointments. Our practice has an after-hour voicemail and text system that patients can utilize by calling/texting 614-717-3500 for the purpose of notifying us of your need to reschedule an appointment. **Broken/missed appointments, late arrivals (more than 15 minutes after your scheduled appointment), and appointments canceled with less than 24 hours notice may be charged $40 per hygiene appointment and $80.00 per hour per doctor appointment.**

By not canceling in a timely manner, our practice is unable to fill those appointment times with other patients who are eager to be cared for in our practice. It is necessary for us to enforce this policy in order to be fair to all our current and future patients. As the demand grows for our services, this policy will decrease the waiting time for all patients and help ensure availability and prompt care. We understand situations arise that may not permit you to give us adequate notice. Exceptions to this policy will be determined on an individual basis according to the circumstances.

I have read and understand the broken appointment policy. By signing below, I acknowledge that I will make every effort to notify the dental staff at least 24 hours in advance if I will not be able to make my scheduled appointments. I also understand that if I break three appointments without notice, I may be asked to separate from the practice.

____________________________________ ______________
Patient Signature (or guardian) Date

____
Print Name

Last updated: 1/15/2021