Powell Dental Group

Shelley D. Shults, RN, DDS & Associates
39 Clairedan Drive, Powell, OH 43065
(614)436.4433

Date: _____

PATIENT INFORMATION

Patient Name: _____ Preferred Name: _____

Birthdate: _____ SS# _____ Driver's License #: _____

Sex: Male ☐ Female ☐

☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

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

Email Address: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Employed: ☐ Full Time ☐ Part Time ☐ Not Employed

Employer: _____ Occupation: _____

Employer Address: _____

Student Status: ☐ Full Time ☐ Part Time ☐ Not Applicable

School Name: _____ School City/State: _____

Emergency Contact Name: _____ Phone: _____ Relation: _____

Who May We Thank for Referring You to Our Office: _____

FINANCIAL INFORMATION

Person Financially Responsible for Account: _____ Relation to Patient: _____

Birthdate: _____ SS#: _____ Driver's License #: _____ Sex: Male ☐ Female ☐

Home Address: _____

City: _____ State: _____ Zip: _____

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

Employer Name: _____ Email Address: _____

please note for children, the parent/guardian that brings the child to their appointment is responsible for payment on the account

DENTAL INSURANCE INFORMATION

Primary Dental Insurance:

Insured Name: _____ Relation to Patient: _____

Birthdate: _____ SS#: _____ Subscriber ID #: _____

Employer: _____ Occupation: _____

Employer Address: _____

Insurance Company: _____ Ins. Co. Phone #: _____ Group #: _____

Secondary Dental Insurance:

Insured Name: _____ Relation to Patient: _____

Birthdate: _____ SS#: _____ Subscriber ID #: _____

Employer: _____ Occupation: _____

Employer Address: _____

Insurance Company: _____ Ins. Co. Phone #: _____ Group #: _____

By Signing Below, I verify the information provided is accurate to the best of my knowledge.

Patient Name	**Name of Responsible Party**	**Signature of Responsible Party**	**Date**

DENTAL HISTORY

Dentist: _____ City, State: _____ Date of Last Visit: _____ Date of Last X-rays: _____

Please check all that apply:

□ Bad Breath □ Loose Teeth or Broken Fillings □ Sensitivity to Sweets □ Joint Clicking / Popping
□ Bleeding Gums □ Current/Past Orthodontic Treatment □ Sensitivity to Hot/Cold □ Blisters on Lips/Mouth
□ Tooth Pain □ Dry Mouth □ Sensitivity to Biting □ Bumps / Growths in Mouth
□ Grinding Teeth □ Jaw/Joint Pain □ Swollen/Tender/Bleeding Gums
□ Food / Floss Catch Between Teeth □ Other: _____

MEDICAL HISTORY

Primary Care Physician's Name: _____ Date of Last Visit: _____ Phone Number: _____

Referring Physician's Name: _____ Referring Physician's Phone Number: _____

Are you currently under the care of a physician? Y / N If yes, please describe: _____

Other Physicians Currently Seeing: _____

Please check all that apply:

□ AIDS/HIV □ Depression □ Insomnia □ Sinus Trouble
□ Abnormal Bleeding □ Diabetes Type 1/II □ Kidney Disease □ Skin Rash
□ Anemia □ Dizziness □ Liver Disease □ Sleep Apnea – Obstructive/Central
□ Anxiety □ Drug Addiction □ Low Blood Pressure □ Snoring
□ Arthritis □ Emphysema/COPD □ Lung Mass □ Stomach Problems / Ulcers
□ Artificial Heart Valve(s) □ Epilepsy/Seizures □ Mitral Valve Prolapse □ Stroke / TIA
□ Artificial Joint(s) □ Fainting □ Osteoporosis □ Swelling of Feet/Ankles
□ Asthma □ Glaucoma □ Pacemaker □ Swollen Neck Glands
□ Back Problems □ Headaches □ Peripheral Vascular Disease □ Thyroid Problems/Disease
□ Bruises Easily □ Heart Attack / MI □ Peptic Ulcers □ Tobacco Use
□ Cancer, Type/Diagnosis: _____ □ Pregnant- ____ weeks __Cigarettes _____/day
□Chemical Dependency □ Heart Murmur □ Psychiatric Care __ Smokeless Tobacco
□ Chemotherapy □ Heart Conditions □ Radiation Treatment __ Other
□ Chronic Fatigue Syndrome □ Hepatitis – Type____ □ Reflux / Hiatal Hernia □ Tuberculosis (TB)
□ CHF (Heart Failure) □ Herpes □ Sarcoidosis □ Venereal Disease
□ Chronic Pain □ High Blood Pressure □ Seizures □ Previous/Current Use of CPAP
□ Other Medical Illnesses Not Listed: _____ □ Previous Sleep Testing _____

Drug/Medication Allergies: □ Allergy to Local Anesthetic □ Allergy to Latex

Medicine	Reaction	Medicine	Reaction

List any Prior Surgical History and Dates:

Date	Surgery

List any other Hospital Admissions in the past:

Date	Surgery

Please list any current medications including prescribed, over-the-counter (herbals, vitamins) you are presently taking:

Medication	Dosage	Reason for Taking

Health Maintenance:

Do you get a yearly Influenza vaccine? □ No □ Yes Have you ever had a pneumococcal vaccine? □ No □ Yes, Date: _____

Have you ever had a tuberculosis skin test (PPD)? □ No □ Yes If Yes, Date: _____ (□ Positive □ Negative)

I have reviewed the information provided on the form and have completed it to the best of my knowledge. I understand this information will be used by the Doctor and Staff to aid with the dental/medical treatment provided for myself/dependent. The information provided will be held in strict confidence in accordance with HIPAA Regulations. If there is a change in my health, it is my responsibility to notify the doctor/staff accordingly. I authorize Powell Dental Group to take digital x-rays, photographs, study models or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I authorize payment directly from my insurance company to Powell Dental Group for all insurance benefits otherwise payable to me for services rendered. I authorize Powell Dental Group to release any and all information necessary to my insurance company, if required, strictly for the purpose of acquiring reimbursement for dental services. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

Patient Name	Name of Responsible Party	Signature of Responsible Party	Date

Powell Dental Group

Shelley D. Shults, RN, DDS & Associates
39 Clairedan Drive, Powell, OH 43065
(614)436.4433

Financial Policy

We welcome you and your family to Powell Dental Group, the office of Dr. Shelley Shults & Associates. We look forward to providing you with the most exceptional dental care. To provide you with the most beneficial and comprehensive service and care, we do ask that you review and complete our office and financial policy consent form. We will gladly discuss your proposed treatment, financial options and any other questions you may have. We strive to keep you informed and involved with your dental treatment as much as possible. We feel that communication between the office/patient is essential to provide excellent dental care to avoid the least amount of confusion.

- *Payment for treatment is due at the time services are provided. Accepted forms of payment include cash, check, Mastercard, Visa, Discover, and American Express. Financing options with credit approval is also available with CareCredit and Springstone Finance.*
- *Any personal check returned unpaid or with non-sufficient funds (NSF) will incur a $50 NSF check fee in addition to the account balance.*
- *If you have dental insurance, copayments and deductibles are due at the time of service. If a copayment needs to be billed, there will be a $15 processing fee.*
- *If a minor is unaccompanied for their dental appointment and a copayment is due, arrangements must be made with the office prior to the appointment.*
- *We accept any insurance that allows patients to see any dentist of their choice. It is the patient's responsibility to verify if Powell Dental Group is in network for their insurance carrier.*
- *As a complimentary service, Powell Dental Group will file your claims for you. We do ask that the correct insurance information be provided so we can submit your claim accurately. If incorrect information is provided, you will be required to pay for your visit in full at the time of service. You can personally submit your claim to your insurance company for reimbursement.*
- *We emphasize that as dental care providers, our relationship is with you, not the insurance company. If difficulty arises with payment from the insurance company, we will ask that you contact your carrier directly to rectify the problem. All unpaid insurance balances older than 90 days from the date of service becomes the immediate responsibility of the patient/account holder. Please be aware that some services you may receive may not be covered by your insurance. Any estimate of insurance payment given by our office does not guarantee that your insurance company will reimburse us/you according to the estimate. Any unpaid balance not paid by the insurance company is the responsibility of the patient.*
- *Balances older than 90 days will be subject to a monthly billing charge of $5.00 if payment is not received on the account. Any balance older than 90 days will be subject to interest charges of 1.5% per month until the account is paid in full. The past due account balance older than 90 days risks being sent to a collection agency. Any additional collection fees will be applied to the past due account balance and are the responsibility of the patient.*
- *In an effort to keep dental costs down while maintaining a high level of professional care, we respectfully request a 24 hour notice for cancellation of an appointment. If a 24 hour notice is not given for dental appointments, a $50 charge to your account may be applied. For Sleep Study Appointments, if a 48 hour notice is not given, a $250 cancellation fee will be applied. We appreciate your efforts to keep scheduled appointments and we will make every effort to continue to have convenient hours and prescheduled availability for you.*
- *If you are 10 minutes late for your appointment, at the office manager's discretion, you may be asked to reschedule and may be charged a missed appointment fee.*

Our Purpose Statement is to provide services that exceed our patient's expectations with compassion, excellence and value, serving each other with care and respect, operating a practice that is strong, financially sound and state of the art, committed to never ending improvement. We pride ourselves in communication with our patients. If at any time you have any questions, please do not hesitate to ask.

By signing this form, I acknowledge that I have read and understand Powell Dental Group's office policies. I have had the opportunity to have any questions answered to the best of Powell Dental Group's ability.

Patient Name	Name of Responsible Party	Signature of Responsible Party	Date

Powell Dental Group

Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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 Updated Notice takes effect April 24, 2014 and will remain in effect until we replace it.

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 in accordance with Section 164.520 of the code of Federal Regulations. 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 you may contact:

Powell Dental Group, Dr. Shelley D. Shults, RN, DDS, LLC
39 Clairedan Drive, Powell, Ohio 43065
(614)436-4433 Email: contactus@powelldentalgroup.com

If you believe your privacy rights have been violated, you may make a complaint to the above address.
The individual will not be retaliated against for making a complaint.

SECTION A: PERSON/PATIENT GIVING CONSENT

Patient Name: _____ DOB: _____

Parent/Legal Guardian Name: _____

Address: _____

Telephone: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. During the course of dental treatment, it may become necessary to disclose your protected health information to another entity, and agree to give consent to such disclosure for these permitted uses, including disclosures via email/fax.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description or our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent as permitted by Section 164.506 of the code of Federal Regulations.

SECTION C: USE AND DISCLOSURE OF HEALTH INFORMATION

(You are not required to share/restrict information to anyone)

I, _____, wish to (☐ allow ☐ restrict) disclosure of my health information to:

_____ (name), _____ (relationship).

I may revoke this disclosure with written notice to Powell Dental Group at any time.

SECTION D: SIGNATURE

I have had the full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand by signing this Consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Patient/Legal Guardian Signature: _____ Date: _____

If acting on behalf of a minor or if you are the legal guardian/Medical Power of Attorney, please inform Powell Dental Group of:

Patient's Name: _____ Your Relation to Patient: _____