Periodontal Associates, Inc.

WELCOME TO THE OFFICE OF
Dr. Roger Hess • Dr. Rebecca Davis • Dr. Miguel DeFina • Dr. Jason Streem
SPECIALISTS IN PERIODONTOLOGY • IMPLANTOLOGY

CONFIDENTIAL

Patient Name:_____ DOB_____ SS#_____

Address_____

City_____ State____ Zip_____ Home Phone_____ Cell Phone_____ Work Phone_____

Email_____ ○ Male ○ Female ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Employer_____ Occupation_____

Spouse_____ DOB_____ SS#_____

Employer_____ Occupation_____

*DENTAL INSURANCE PRIMARY*_____ Sub. ID#_____

Primary Address_____ Grp#_____

*DENTAL INSURANCE SECONDARY*_____ Sub. ID#_____

Secondary Address_____ Grp#_____

*EMERGENCY CONTACT NAME*_____ PHONE_____

*GENERAL DENTIST NAME/Referred by*_____

*PHONE*_____ *ADDRESS*_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with (name of insurance company(ies)_____
and assign directly to Periodontal Associates, Inc. all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance.

*SIGNATURE*_____ DATE_____

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor or child. I accept full financial responsibility for all charges not covered by insurance.

*SIGNATURE*_____ DATE_____

INFORMED CONSENT

All the risks, complications, prognosis, treatment and alternatives have been explained to me. I have had the opportunity to ask any relative questions to the recommended treatment. I agree to accept the proposed treatment outlined.

SIGNED: PATIENT, PARENT OR GUARDIAN_____ DATE_____

ACKNOWLEDGMENT AND RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (patient, parent or guardian)_____
have received a copy of this office's NOTICE OF PRIVACY PRACTICES.

*PRINT*_____

*SIGNATURE*_____

*DATE*_____

FOR OFFICE USE ONLY: We attempted to obtain written knowledge of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign ☐ Communications barriers prohibited obtaining acknowledgment

☐ An emergency prevented us from obtaining acknowledgment ☐ Other- Please specify_____

PLEASE TURN THIS PAGE OVER AND COMPLETE THE OTHER SIDE!!

MEDICAL HISTORY

Physicians Name_____ Hospital_____ Phone_____

How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you been hospitalized in the last 5 years? _____ ☐ YES ☐ NO

*If yes please explain:*_____

PLEASE CHECK ANY ILLNESSES/CONDITIONS YOU HAVE EVER HAD:

☐ Anemia or blood problems ☐ Bleeding Disorders ☐ Drug or Alcohol Abuse ☐ HIV/AIDS ☐ Heart Problems

☐ Epilepsy/Seizures ☐ Kidney/Bladder Problems ☐ High Blood Pressure ☐ Emphysema/COPD ☐ Glaucoma ☐ Thyroid

☐ Diabetes: Last A1c_____When?_____ ☐ Artificial Heart Valve ☐ Liver Problems ☐ Tuberculosis ☐ Asthma

☐ Ulcer/Colitis ☐ Hepatitis A, B, C ☐ Stroke/When?_____ ☐ Cancer/Type:_____Chemo Schedule_____

ARE YOU TAKING ANY MEDICATIONS? _____ ☐ YES ☐ NO

IF YES PLEASE LIST ALL MEDICATIONS:_____

_____

*NAME/LOCATION OF YOUR PREFERRED PHARMACY/PHONE:*_____

_____

*Do you take BLOOD THINNERS?*_____ INR Value and Date_____ ☐ YES ☐ NO

(EX: Coumadin/Warfarin, Pradaxa, Xarelto, Eliquis)

*Do you take a daily ASPIRIN? If so what dosage?*_____ ☐ YES ☐ NO

JOINT REPLACEMENT:

Have you had orthopedic total joint replacement? (Hip, Knee, Shoulder, Elbow, Finger)_____ ☐ YES ☐ NO

Date of Surgery:_____If yes, have you had any complications?_____

PREMEDICATION:

DO YOU TAKE antibiotics before dental visits to prevent heart/joint infections?_____ ☐ YES ☐ NO

Have you ever taken drugs by mouth or injection to strengthen bone for conditions such as Osteoporosis, Multiple Myeloma, Paget's Disease, Breast, Prostate or Metastatic Cancer?

_____ ☐ YES ☐ NO

(EXAMPLES: Fosamax, Actonel, Boniva, Reclast, Prolia, Aredia, Zometa or Xgeva?)

If YES, how long have you been taking this?_____If no longer, when did you stop?_____

DO YOU HAVE ANY KNOWN ALLERGIES: _____ ☐ YES ☐ NO

IF YES PLEASE LIST:_____

_____

Do you have any sensitivity to Latex or Latex products? _____ ☐ YES ☐ NO

Do you smoke, vape or use tobacco in any other form? _____ ☐ YES ☐ NO

Packs per Day?_____Years of Use?_____

DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEMS NOT LISTED THAT YOU BELIEVE WOULD AFFECT YOUR TREATMENT IN ANY WAY?_____ ☐ YES ☐ NO

*If yes please explain:*_____

FEMALES ONLY:

Are you pregnant?_____ _____ ☐ YES ☐ NO

Are you taking birth control pills?_____ ☐ YES ☐ NO

PLEASE LOOK THIS FORM OVER TO BE SURE YOU HAVE ANSWERED EVERY QUESTION, THANK YOU!!

PERIODONTAL ASSOCIATES, 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 January 20, 2014, 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 and/or text 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 for each page, for staff time to 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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services.

Contact Officer: Dr. Rebecca Davis
Telephone: (440) 461-3400 Fax: (440) 461-1722
E-mail: info@clevelandperio.com
Address: 29001 Cedar Rd., Suite 450, Lyndhurst, OH 44124