	© 2012 Wisconsin Dental Association (800) 243-4675
welcome	Age Date
Patient's Name	Date of Birth Date of Birth Initial
If Child: Parent's Name How do you wish to be addressed	DENTAL INSURANCE 1ST COVERAGE
Single Addressed Divorced Widowed A N Residence - Street	Minor Date of Birth Date of Birth Relationship to patient
City State Zip Business Address	Employer Name       Yrs.         Name of Insurance Co.       Address

Telephone: Res Bus	Program
Fax Cell Phone #	Social Se
eMail	Union Lo
Patient/Parent Employed By	
Present Position	Employe
How Long Held	Employe Name of
Spouse/Parent Name	Addrose
Spouse Employed By	Telephor
Present Position	Program Social Se
How Long Held	Union Lo
	CONSE

Telephone	
Program or policy #	
Social Security No.	
Union Local or Group	
	DENTAL INSURANCE 2ND COVERAGE
Employee Name	Date of Birth
Relationship to patient	
Employer Name	Yrs.
Name of Insurance Co.	
Address	
Telephone	
Program or policy #	
Union Local or Group	
OONOFNT.	

## ENI:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Who is Responsible for this account

Drivers License No.

Method of Payment: Insurance 
Cash Cash Credit Card

Purpose of Call

Other Family Members in this Practice

Whom may we thank for this referral \_\_\_\_\_

Patient/parent Social Security No.

Spouse/Parent Social Security No.

Someone to notify in case of emergency not living with you \_\_\_\_\_

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care oper-ations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

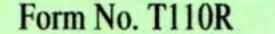
My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits other-wise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for pay-ment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

DATE \_\_\_\_\_





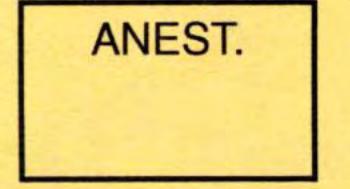
PATIENT NUMBER		© 2012 Wisconsin Dental Association (800) 243-4675
Welcome Patient's NameLast	First	Initial Date of Birth
1. Purpose of initial visit		COMMENTS
2. Are you aware of a problem?		
3. How long since your last dental visit?		
4. What was done at that time?		
5. Previous dentist's name		
6. When was the last time your teeth were cleaned?		
CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.		

7. Have you made regular visits?	YES NO
8. Were dental x-rays taken?	YES NO
9. Have you lost any teeth or have any teeth been removed?	
10. Have they been replaced?	YES NO
11. How have they been replaced?	
a. Fixed bridge Age	
a. Fixed bridge Age b. Removable bridge Age	
c. Denture Age	
d. Implant Age	
12. Are you unhappy with the replacement? If yes, explain	YES NO
13. Would you like to know about permanent replacements?	YES NO
14. Have you ever had any problems or complications with previous dental treatment' If yes, explain:	?YES NO
15. Do you clench or grind your teeth?	YES NO
16. Does your jaw click or pop?	YES NO
17. Have you experienced any pain or soreness in the muscles or your	
face or around your ear?	YES NO
18. Do you have frequent headaches, neckaches or shoulder aches?	
19. Does food get caught in your teeth?	
20. Are any of your teeth sensitive to:	
21. Do your gums bleed or hurt?	
When?	
22. Do you experience dry mouth?	YES NO
23. How often do you brush your teeth? When?	
24. Do you use dental floss?	YES NO
25. Are any of your teeth loose, tipped, shifted or chipped?	YES NO
26. Are you unhappy with the appearance of your teeth?	
27. How do you feel about your teeth in general?	
28. Do you feel your breath is offensive at times?	
29. Have you ever had gum treatment or surgery?	
What?	
Where?	
When?	
30. Have you had any orthodontic work?	
31. Have you had any unpleasant dental experiences or is there anything about denti strongly dislike?	stry that you
	VEO NO

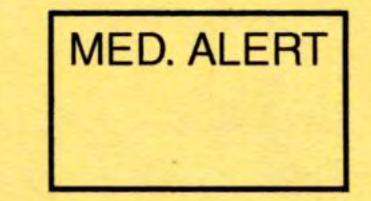
# I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE PATIENT'S / GUARDIAN'S SIGNATURE\_\_\_\_\_

DENTIST'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

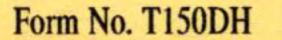


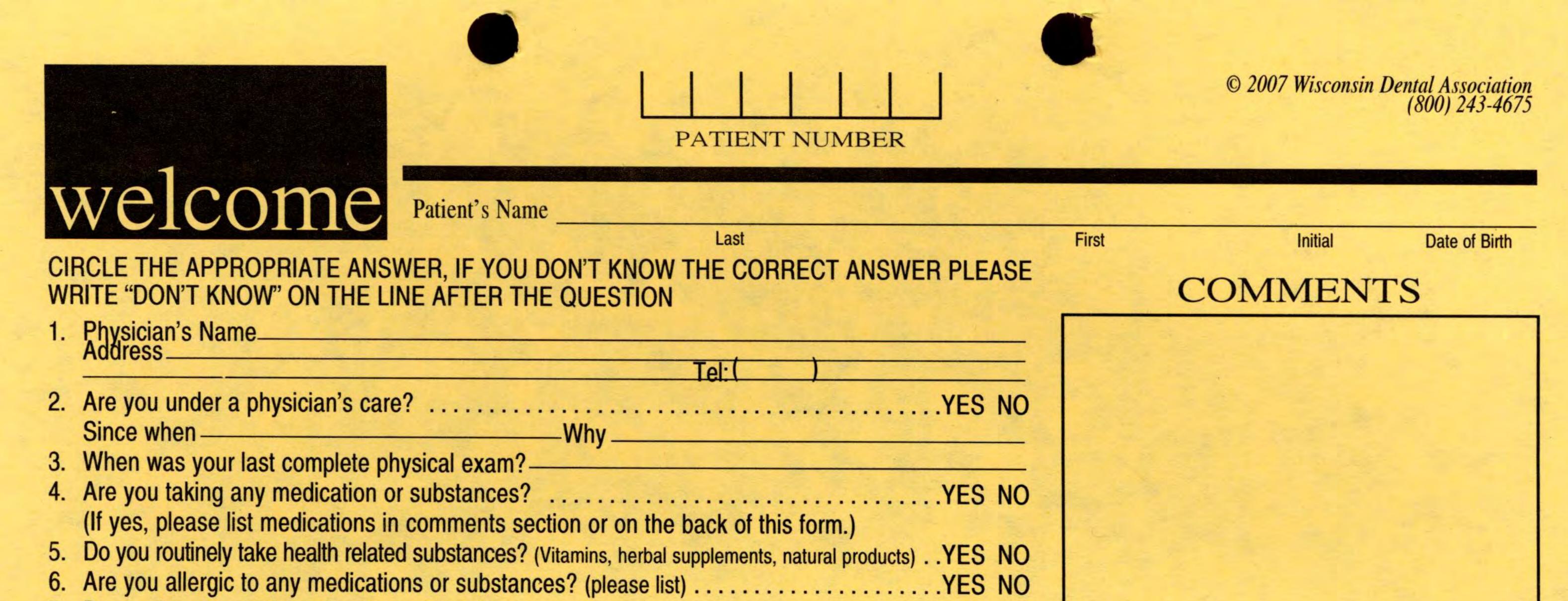


# DENTAL HISTORY



\_\_DATE\_\_\_\_\_



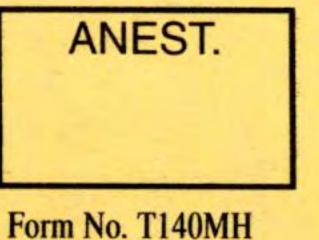


7. Do you have any other allergies or hives?	YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics	
or other medications?	YES NO
9. Are you sensitive to any metals or latex?	
10. Are you pregnant or suspect you may be?	YES NO
11. Do you use any birth control medications?	YES NO
12. Have you ever been treated for or been told you might have heart disease?	YES NO
13. Do you have a pacemaker, an artificial heart valve implant, or	
been diagnosed with mitral valve prolapse?	YES NO
14. Have you ever had rheumatic fever?	YES NO
15. Are you aware of any heart murmurs?	YES NO
16. Do you have high or low blood pressure? (please circle)	YES NO
17. Have you ever had a serious illness or major surgery?	YES NO
If so, explain	
18. Have you ever had radiation treatment, chemo treatment for tumor,	
growth or other condition?	YES NO
19. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenou	s treatment
(bisphosphonates) for bone tumors, excessive calcium in your blood, or osteop	orosis? YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism?	
21. Do you have any artificial joints/prosthesis?	YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc?	YES NO
23. Have you ever bled excessively after being cut or injured?	YES NO
24. Do you have any stomach problems?	YES NO
25. Do you have any kidney problems?	YES NO
26. Do you have any liver problems?	YES NO
27. Are you diabetic?	YES NO
28. Do you have fainting or dizzy spells?	YES NO
29. Do you have asthma?	YES NO
30. Do you have epilepsy or seizure disorders?	YES NO
31. Do you or have you had venereal or any sexually transmitted disease?	YES NO
32. Have you tested HIV positive?	YES NO
33. Do you have AIDS?	YES NO
34. Have you had or do you test positive for hepatitis?	YES NO
35. Do you or have you had T.B.?	YES NO
36. Do you smoke, chew, use snuff or any other forms of tobacco?	YES NO
37. Do you regularly consume more than one or two alcoholic beverages a day? .	YES NO
38. Do you habitually use controlled substances?	YES NO
39. Have you had psychiatric treatment?	YES NO
40. Have you taken any prescription drugs fenfluramine, fenfluramine combined with	
nhentermine (fen-nhen) devfenfluramine (reduv) or other weight loss products	

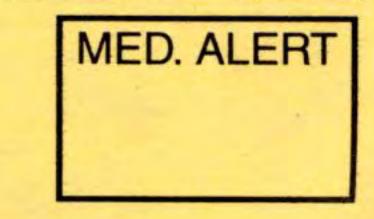
41. Do you have any disease condition, or problem not listed? If so, explain \_\_\_\_\_

42. Is there anything else we should know about your health that we have not covered in this form?

# DENTIST'S SIGNATURE\_\_\_\_\_



**MEDICAL HISTORY** 



DATE

DATE.

## Hoban Dentistry

Wisconsin Dental Association (800) 243-4675

[Insert Name of Practice]

### **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

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe in this notice while it is in effect. This notice takes effect April 14, 2003, 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 applicable law permits the changes. 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 health care operations. For example: **Treatment:** We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: 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 uses 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 may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;

- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our
  premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- · to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

#### 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 request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. 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 may—but are not required to—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 more information about fees.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. 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. Contact us using the information listed at the end of this notice for more information about fees.

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). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

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. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment 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 we should amend the information. We may deny your request under certain circumstances.

#### QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- · our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed below. 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.

Hoban Dentistry	y	
Provider Contact Office: 513-858-1600	Fax: 513-858-2012	
E Maile jessica@hobandentistry.com		-
Address:_5184 Winton Road, Fairfield,	Ohio 45014	Ø Michael Best & Friedrich, LLC
Form No. T302HN	na years (c) national angles of \$1711 bit is	() Michael Best & Friedrich, LLC

# Hoban Dentistry

[Insert Name of Practice]	
Name:	
Address:	
Telephone:	E-mail:
Patient Number:	Social Security Number:
SECTION B: Acknowledgement of Receipt of Privacy Practices	Notice.
I, Privacy Practices from the above-named practice.	, acknowledge that I have received a Notice of
Signature:	
Personal Representative's Name:	
Relationship to Individual:	
SECTION C: Good Faith Effort to Obtain Acknowledgement of	Receipt
Describe your good faith effort to obtain the individual's signature	e on this form:
Describe the reason why the individual would not sign this form:	
SIGNATURE. I attest that the above information is correct.	
Signature:	_ Date:
Print name:	Title:
ACKNOWLEDGEME PRIVACY PRAC	



#### **Appointment Cancellation and No-Show Policy**

At Hoban Dentistry, we strive to provide exceptional dental care and service to all our patients. In order to maintain the efficiency of our practice and accommodate the needs of all our patients, we have implemented the following **Appointment Cancellation and No-Show Policy**.

#### **Appointment Cancellation:**

- We understand that circumstances may arise that require you to cancel or reschedule your appointment. We kindly ask that you provide us with at least 24
   Hours' Notice if you need to cancel or reschedule your appointment.
- To cancel or reschedule an appointment, please contact our office during business hours at (513) 858-1600
- Failure to provide at least 24 hours notice for cancellation or rescheduling may result in a Cancellation Fee (\$50.00).

#### **No-Show Policy:**

- A "No-Show" is defined as missing an appointment without prior notification or cancellation.
- To ensure the availability of our services to all patients, we have implemented a No-Show Fee Policy.

#### • No-Show Fee \$50.00



Thank you for your cooperation and understanding. If you have any questions or concerns regarding this policy, please feel free to contact our office. We appreciate the opportunity to serve your dental needs.

Patient's Signature and/orGuardian _	
Print Name	

Date\_\_\_\_\_

Hoban Dentistry, LLC

5184 Winton Road

Fairfield, Ohio 45014

(513) 858-1600

sherry@hobandentistry.com