# The Snevel Dental Group Registration and Health History Form (Please Print)

**REGISTRATION INFORMATION**

Date ________________

Patient Name ______________________________________________________________________

Last name First Name Initial Preferred Name

Street Address ____________________________________ City ____________________ State ________ Zip __________

Home Phone __________________ Cell Phone ________________ Email Address: ____________________________

Best Contact Method ___ Home ___ Cell ___ Work ___ Email Sex ___M ___F Birthdate______________

Status ___Single ___ Married ___ Widowed ___Separated ___Divorced

Employed By ____________________________________ Occupation: ______________________________

Business Address ______________________________________________ Work # ________________ Ext _________

Spouse/Parent Name ____________________________________________ Spouse/Parent Birthdate _______________

Spouse/Parent Employed By ____________________________________ Occupation __________________________

Business Address ______________________________________________ Work # __________________ Ext ________

Who is responsible for this account ? ______________________________ Relationship to Patient ______________

Social Security # ____________________________ Spouse/Parent Social Security # ____________________________

In case of emergency, who should be notified? _________________________________ Phone # _________________

Whom may we thank for referring you? __________________________________________________________________

**MINOR/CHILD CONSENT**

I, being the parent/guardian of ________________________________________ (name of minor/child) do hereby request and authorize the dental staff to perform necessary dental service for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date _____________________________ Signature ________________________________________________________

**INSURANCE INFORMATION**

Primary Insurance Information

Name of Dental Insurance Company ______________________________ Group # ______________________________

Subscriber ___________________________ If not subscriber, relationship to subscriber __________________________

ID # ____________________ Provider 800# ____________________

Insurance Address __________________________________________________________________________________

Secondary Insurance Information

Name of Dental Insurance Company ______________________________ Group # ______________________________

Subscriber ___________________________ If not subscriber, relationship to subscriber __________________________

ID # ____________________ Provider 800# ____________________

Insurance Address __________________________________________________________________________________

Assignment & Release

I hereby authorize payment of insurance benefits otherwise payable to me to be made directly to this dental office. I understand that any insurance coverage estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office. I authorize release of my dental/medical histories and other information about my dental treatment to third party payers.

Date ______________________________ Signature ______________________________________________________

**DENTAL HISTORY**

Do you have a specific dental problem? Describe ______________________________ Yes ___ No ___

Are you apprehensive about dental treatment? ______________________________ Yes ___ No ___

Have you had problems with previous dental treatment? ______________________________ Yes ___ No ___

Do you have a dental examination on a routine basis? Last visit______________________________ Yes ___ No ___

Do you think you have active decay or gum disease? ______________________________ Yes ___ No ___

Do you brush and floss on a routine basis? Discuss ______________________________ Yes ___ No ___

Do your gums ever bleed? Do they bleed when you floss? Discuss ______________________________ Yes ___ No ___

Do your gums feel swollen or tender? ______________________________ Yes ___ No ___

Do you gag easily? ______________________________ Yes ___ No ___

Do you wear partials or dentures? ______________________________ Yes ___ No ___

Do you like your smile? Why? ______________________________ Yes ___ No ___

Does food catch between your teeth? ______________________________ Yes ___ No ___

Any loose teeth? ______________________________ Yes ___ No ___

Do you prefer to save your teeth? ______________________________ Yes ___ No ___

Do you have difficulty chewing your food or chew on only one side of your mouth? ______________________________ Yes ___ No ___

Do you ever have clicking, popping or discomfort in the jaw joint? ______________________________ Yes ___ No ___

Do you clench or grind your teeth? ______________________________ Yes ___ No ___

Have your past experiences in a dental office always been positive?______________________________ Yes ___ No ___

Do you smoke or chew?______________________________ Yes ___ No ___

Any sores or growths in your mouth? Discuss ______________________________ Yes ___ No ___

Are your teeth sensitive? ______________________________ Yes ___ No ___

Do you feel twinges of pain when your teeth come in contact with hot, cold, sour or sweet foods/liquids? Yes ___ No ___

Name of previous Dentist (Optional) ______________________________

Date of last full mouth x-rays (16 small films or panaramic) ______________________________

**MEDICAL HISTORY**

Physician's Name & Phone # ______________________________ Date of Last Physical ____________

Have you ever had any of the following? (Check all that apply)

| | | |
|---|---|---|
| ___ Heart Problems | ___ Epilepsy | ___ Special Diet |
| ___ High Blood Pressure | ___ Headaches | ___ Swollen Neck Glands |
| ___ Low Blood Pressure | ___ Hepatitis, Jaundice or Liver Disease | ___ Rheumatic Fever |
| ___ Circulatory Problems | ___ Cancer | ___ Sinus Problems |
| ___ Nervous Problems | ___ Psychiatric Care | ___ Thyroid Disease |
| ___ Radiation Treatment | ___ Chronic Diarrhea | ___ Stroke |
| ___ Artificial Heart Valves or Joints | ___ Allergies to Anesthetics | ___ Ulcer |
| ___ Recent Weight Loss | ___ Allergies to Medicine or Drugs | ___ Veneral Disease |
| ___ Back Problems | ___ General Allergies | ___ Chemical Dependency |
| ___ Diabetes | ___ Blood Disease | ___ Hemophilia |
| ___ Respiratory Disease | ___ Arthritis | ___ HIV / AIDS or Other Immunosuppressive Disorders |

Are you under the care of a Physician? ___ Yes ___ No If yes, what condition? ______________________

Have you ever been hospitalized or had a major operation? ______________________

Do you have any drug allergies or have you ever had an adverse reaction to any medication? ______ If yes, please describe ______________________

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Bonive. ___ Yes ___ No

Have you ever responded adversely to medical or dental treatment? ______________________

Are you taking any medication at this time? _____ If yes, what? ______________________

Have you ever taken any of the group of drugs collectively referred to as a "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexdenfluramine).
___ Yes ___ No

Are you under the care of a Physician? ___ Yes ___ No If yes, what condition? ______________________

(Women) Do you suspect that you are pregnant? ___ Yes ___ No Are you nursing? ___ Yes ___ No

Is there anything else we should know about your medical history? ______________________

______________________________________________________________________

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date __________________ Signature ______________________________

# The Snevel Dental Group Financial Policy

Thank you for choosing **The Snevel Dental Group** for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options in order to help you receive the dental care you need and deserve, allowing you to enjoy a healthy, beautiful smile with respect to your time and budget. Dental treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer any of your questions or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment.

**Optional Payment Terms:**

1. **Payment Methods**: We accept cash, check, and any major credit card, as well as CareCredit (explained below under #4).

2. **Full Pay Cash Courtesy (for patients without insurance)**: We offer a 5% accounting courtesy on treatments exceeding $300.00, if paid in full (cash or check), at or before the time of service. On treatments exceeding $1000.00 we offer a courtesy of 10%.

3. **Major Service – Two Payment Option:** We offer a two-payment option for procedures in excess of $1000.00. We ask that you pay one-half of your payment at the first appointment and the second half prior to the final appointment.

4. **CareCredit Financing**: By arrangement with CareCredit, we offer our patients, upon approval, financing options for 6 and 12 months (no interest if paid in full and on time). We also have available extended plans ranging from 12 months to 5 years. (The extended plans have a low interest rate). An application for CareCredit can be processed in our office.

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I have read and agree to the terms set out for The Snevel Dental Group Financial Policy.

I understand that I am responsible for any charges that occur in the office of The Snevel Dental Group and that arrangement with my insurance provider and myself are my responsibility.

________________________________________

Signed Date

________________________________________

Name (Printed) Date

# The Snevel Dental Group Appointment Policy

1. I understand that a cancellation of my appointment requires at least 24 hour notice to the office.

2. Any cancellation or "no show" without 24 hour notice will be logged in patient's record as a "Broken Appointment."

3. I understand that if I am late to my appointment by more than 20 minutes, I may be asked to reschedule, and this may be considered a "Broken Appointment."

4. After 2 broken appointments, I understand that it may result in a "Broken Appointment Fee" of $125.00.

5. Following 5 broken appointments, I understand that I may be asked to leave the practice.

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I have read and agree to The Snevel Dental Group's Appointment Policy.

______________________________

Signed Date

______________________________

Name (printed) Date

## The Snevel Dental Group Notice of Privacy Policy

This Notice of Privacy Practice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law. It also describes your right to access and control your protected health information. "Protected Health Information (PHI)" is information about you, including demographic information that may identify you and that is related to your past, present or future physical or mental health, condition, and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all PHI that we maintain at that time. Upon request, we will provide you with any revised Notice of Privacy Practices, which may be picked up at our office located at 35010 Chardon Rd. Suite 201, Willoughby Hills, OH 44094.

**Uses and Disclosure of Protected Health Information (PHI)**

- Your PHI may be used for treatment, payment, health care operations, and administrative purposes and to evaluate the quality of care that you receive. It may be shared with other medical personnel for treatment purposes. It may be used to obtain payment from insurance companies or third party administrators.
- We may use or disclose PHI about you without authorization for several reasons. Subject to certain requirements, we may give out health information for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when required by law, such as for law enforcement in specific circumstances.
- In any other situations, we will ask for your written authorization before using or disclosing any PHI.
- If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future disclosures.

**Individual Rights**

- In most cases, you have the right to look at or obtain a copy of your health information that we use to make decisions. You may request a "Patient Records Access Request Form" from our office staff. You need to make an appointment with the Supervisor of Medical Records to review this information. If you request copies, we will charge you a per page fee as listed on the request form.
- You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. This service will also be provided for a fee.
- If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information, using the "Request to Amend Records Form." While we will consider your request, we are not required to agree to it.
- You have the right to request in writing, a restriction or limitation on PHI we use or disclose about you. This may include treatment, payment, health care operations, or information that we disclose to someone who may be involved in your care or payment for your care, such as a family member or friend. You must state what information you wish to restrict or limit, whether you want to limit or use, disclosure, or both and to whom the limits apply to. However, while we will consider your request, we are not required to agree to it.

- You have the right to receive confidential communications.
- You have the right to obtain a copy of this notice upon request.

**Complaints**

If you are concerned that we have violated your privacy rights or you disagree with a decision we made about access to your records, you may contact the HIPAA Compliance Office at the address or phone number listed below. You may also file a complaint with Department of Human Service in Washington, D.C. in writing with 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

HIPPA Compliance Officer
35010 Chardon Rd., Suite 201
Willoughby Hills, OH 44094

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I have read and will comply with the Privacy Policies of The Snevel Dental Group.

________________________________________

Signature Date

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Name (Printed) Date