

Dear Parent/Guardian:

We understand that bringing your child to the dentist can be an exciting, but stressful, time and you may feel the need to be with your child during the appointment. However, due to our space limitations in our clinic rooms we ask that you wait in the waiting room while we are providing quality, comprehensive services to your child.

Should we have problems in treating your child, we will call you back immediately.

We appreciate your understanding in this matter. Should you have any questions please ask the dental staff.



## **Notice of Privacy Practices**

Northwest Ohio Dental Clinic  
At Henry County Health Department  
1843 Oakwood Ave.  
Napoleon Ohio 43545  
419-599-5545

**This Notice describes how Dental/Medical Information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.** This Notice is to be read before you agree to the terms of the Consent Form.

A federal privacy law (known as the Health Insurance Portability and Accountability Act) was passed by Congress to further increase the information safeguards and security of patient healthcare information. In this Notice, we will describe the uses and disclosures of Protected Health Information (PHI). PHI is defined as identifiable health information about you that has been collected by a healthcare provider as it relates to your past, present, or future physical or mental health or condition. The Northwest Ohio Dental Clinic/Henry County Health Department has established policies to guard against unnecessary disclosure of your protected health information. This Notice will be revised as needed to reflect any changes in Northwest Ohio Dental Clinic/ Henry County Health Department privacy practices.

### **Consent**

Your consent will be obtained in writing on your first date of service provided by the Northwest Ohio Dental Clinic/HCHD and this will give us permission to use or disclose your PHI to carry out (1) treatment, (2) obtain payment, (3) and to conduct oral health care operations at the health department. We may also use and disclose your health information to contact you as a reminder that you have an appointment. The Northwest Ohio Dental Clinic/Henry County Health Department is allowed and required to disclose PHI without a signed consent for purposes of law enforcement such as reporting abuse, judicial proceedings, and public health activities such as communicable disease investigations. You have the right to revoke, in writing, your consent, but the Northwest Ohio Dental Clinic/Henry County Health Department will not be able to provide further services.

### **Authorization**

Your authorization is required for the use and disclosure of PHI for purposes other than treatment, payment and to conduct health care operations. You may revoke this authorization at any time.

### **Rights of Patients** (or their legal representative)

- 1) To receive a paper copy of this notice.
- 2) To request restrictions on the uses and disclosures of health information (however the health department is not required to agree to the restriction)
- 3) To request to receive confidential communication.
- 4) To request to inspect or obtain a copy of your PHI.
- 5) To amend your health care information.
- 6) To request an accounting of disclosure of health information.

When the Northwest Ohio Dental Clinic/Henry County Health Department is using and disclosing your PHI, they will use the minimum amount of protected health information necessary to perform their job.

### **Contact Person**

The Northwest Ohio Dental Clinic/Henry County Health Department has designated the Director of Nursing as its contact person for all issues regarding patient privacy and your rights under the Federal privacy standards. You may contact her at the health department address. If you believe a violation has occurred, you may file a complaint with the Office of Secretary, Department of Health & Human Services, 200 Independence Avenue SW, Washington D.C., 20201.

# Consent/Authorization to Use & Disclose Dental Health Information

Northwest Ohio Dental Clinic  
At Henry County Health Department  
1843 Oakwood Avenue  
Napoleon Ohio 43545  
419-599-5545

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

## Consent

By signing this consent, I authorize the Northwest Ohio Dental Clinic/Henry County Health Department to use and/or disclose my health information for (1) treatment, (2) payment or (3) health care operations. I have the right not to sign this consent; however, if I refuse to sign this consent, the Northwest Ohio Dental Clinic/Henry County Health Department has the right to refuse to treat me.

My rights with respect to consent include; (1) to receive a paper copy of our Notice of Privacy Practices prior to signing the consent, (2) to request restrictions on the uses and disclosures of health information, (3) the right to revoke the consent at anytime except to the extent that we have already taken certain actions based on the consent prior to revoking it, (4) the right to receive a copy of this consent form after you sign it.

This consent is effective unless and until I revoke it in writing.

I hereby authorize the Northwest Ohio Dental Clinic/Henry County Health Department to use and/or disclose my health information for treatment, payment, or health care operations.

\_\_\_\_\_  
Patient Signature (Guardian or Health Care Power of Attorney)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## Authorization

By signing this authorization form, I authorize the Northwest Ohio Dental Clinic/Henry County Health Department to use and/or disclose my health information in the manner described below. I understand that I am under no obligation to sign this authorization form and that the Northwest Ohio Dental Clinic/Henry County Health Department who I am authorizing to use and/or disclose my information may not condition treatment, payment, or enrollment for health care benefits on my decision to sign this authorization. I have signed this form voluntarily in order to document my wishes regarding the use and/or disclosure of the health information described below.

I authorize the following health information to be used and/or disclosed: (give description)

\_\_\_\_\_  
I authorize the following organization (or person) \_\_\_\_\_  
to receive my listed health information above from the Northwest Ohio Dental Clinic/Henry County Health Department. I understand that if the organization (or person) listed below are not health care providers, health plans or health care clearinghouses subject to federal privacy standards, the health information disclosed in this authorization may no longer be protected by the federal privacy standards and such organizations (person) may redisclose my health information without obtaining my authorization.

Your rights with respect to authorization include; (1) the right to revoke or restrict the authorization, in writing (see HIPAA policy attachment #6A) at anytime except to the extent that we have already taken certain actions based on the authorization prior to revoking it, (2) the right to inspect or copy the health information to be used or disclosed, (3) the right to receive a copy of this authorization.

I have had an opportunity to review and understand the contents of this authorization form. By signing this form, I am confirming that it accurately reflects my wishes.

*This authorization will expire on the **21<sup>st</sup> birthday of the patient (if under 18), or in 2 years.***

\_\_\_\_\_  
Patient Signature (Parent/Guardian or Health Care Power of Attorney)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**The Northwest Ohio Dental Clinic  
at the Henry County Health Department  
Financial Responsibility**

Name \_\_\_\_\_

Date \_\_\_\_\_

The services that may need to be done are indicated below.

- Exam (Emergency, Periodic, Comprehensive)
- X-rays
- Cleaning
- Fillings
- Extractions
- Sealants
- Dentures/Partials/Bridges/Crowns
- Root Canals
- Any other general dentistry that may need to be preformed

The insurance information has been quoted to our Agency by your insurance company. This quotation is not a guarantee of payment for your insurance. The Agency will not be responsible for incorrect information obtained in regard to your policy coverage. You must be prepared to provide your insurance card at every visit. We cannot bill your insurance unless you give us your current insurance information. Your insurance policy is a signed contract between you and your insurance company. Our office is not able to change your contract. It is very important that you know and understand your insurance benefits. Co-payments are due at the time of service, per your agreement with your insurance company.

If you do not have insurance, full payment is expected at the time of service.

\_\_\_\_\_  
Insurance Type

\_\_\_\_\_  
Deductible

\_\_\_\_\_  
Coverage

- Your primary insurance is Medicaid.
- Your primary insurance is Private Insurance. Your secondary is Medicaid.
- Your primary insurance is Private Insurance.
- Private Pay patient will pay for services done on the same day.

**\*WE ACCEPT: CASH OR DEBIT FOR PAYMENT.**

If you have any questions concerning this information or your insurance coverage changes, please notify our office at (419) 591-3060.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Northwest Ohio Dental Clinic  
1843 Oakwood Avenue  
Napoleon, Ohio 43545  
419-591-3060

**Statement of Patient Understanding Regarding Missed or Broken Appointments  
without Giving 24hrs Notice**

I, \_\_\_\_\_, a patient of the Northwest Ohio Dental Clinic at the Henry County Health Department, understand that if I do not cancel my or my family member's dental appointment **without giving 24 hours notice** that our family **will not be seen for three months per missed appointment.**

I also understand that if my family member or I have **other appointments scheduled**, that those appointments will also be **cancelled.**

I also understand that if the dental clinic **does not have a current phone number** for me and they call to confirm my appointment the day before and the **phone is no longer in service, my dental appointment will be cancelled.**

If I need to come to the dental clinic prior to my waiting period, I can wait in the waiting room to see if an appointment becomes available. **I understand that if everyone shows for that day, I will not be seen.**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Dental Clinic Staff Signature

\_\_\_\_\_  
Date

# Northwest Ohio Dental Clinic Demographic Assessment

Instructions:

1. Please **do not** put your name on this survey.
2. Please complete the following questions on patient being seen.
3. Please return to Dental Clinic Check-In.

**1. Please mark your ethnicity:**

- Hispanic  
 Non-Hispanic

**2. Please mark your race (you may mark more than one of the answers):**

- White/ Caucasian  
 Black/ African American  
 Asian  
 Native Hawaiian/Pacific Islander  
 American Indian/ Alaskan Native  
 Other: \_\_\_\_\_

**3. Please mark your age range:**

- 0 – 4 years  
 5 – 12 years  
 13 – 21 years  
 22 – 44 years  
 45 – 64 years  
 65 + years

**4. Please mark your gender:**

- Male  
 Female

# Welcome

Thank you for selecting the Northwest Ohio Dental Clinic. We all strive to provide you with the best possible dental care. To help us meet all your dental needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us- we will be happy to help.

## Patient Information (Confidential):

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_ Text OK? \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Today's Date: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female: \_\_\_\_\_  
Is an interpreter needed? \_\_\_\_\_ If yes, language needed: \_\_\_\_\_  
Is Transportation a problem? \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## Responsible Party:

Person Responsible for Patient: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_  
Is this person a current patient of the clinic?  Yes  No

## Payment Information:

\_\_\_\_\_ **Medicaid/ Healthy Start and Healthy Families**  
(Please provide card to check-in staff to make a copy for the patient's record.)  
\_\_\_\_\_ **Self-Pay** (Please provide pay stubs to check-in staff to make a copy for patient's record.)  
Household Size: \_\_\_\_\_

*Over Please*

## Office Use Only

**SELF-PAY** Date: \_\_\_\_\_  
Weekly Gross Income: \$ \_\_\_\_\_ **MEDICAID:**  
Monthly Gross Income: \$ \_\_\_\_\_ Plan: \_\_\_\_\_  
Yearly Gross Income: \$ \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Sliding Fee Scale Percentage: \_\_\_\_\_ %

# Patient Medical History

Name \_\_\_\_\_ Patient's Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

- Are you under medical treatment?  Yes  No
- Have you been hospitalized for any surgical operation or serious illness within the last 5 years?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Are you taking any medications, including non-prescription?  Yes  No  
If yes, please list medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Have you taken or are you taking any IV or Oral Bisphosphonates (Osteoporosis medication)?  Yes  No
- Are you taking Coumadin, Warfarin, Plavix or any blood thinners?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

**Women Only:**

Are you pregnant/think you are?..  Yes  No

Are you nursing? .....  Yes  No

Are you taking oral contraceptives?..  Yes  No

8. Are you allergic to or have you had any reactions to any of the following:
- |  |   |
|--|---|
| - Local Anesthetics (e.g. Novocain).... <input type="checkbox"/> Yes <input type="checkbox"/> No   | - Sulfa Drugs ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| - Penicillin or other antibiotics ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | - Barbiturates ..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| - Sedatives..... <input type="checkbox"/> Yes <input type="checkbox"/> No                          | - Iodine..... <input type="checkbox"/> Yes <input type="checkbox"/> No        |
| - Any metals (e.g. nickel, mercury) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No | - Aspirin ..... <input type="checkbox"/> Yes <input type="checkbox"/> No      |
| - Latex/Rubber..... <input type="checkbox"/> Yes <input type="checkbox"/> No                       | - Other: _____  |

9. Please mark the box if you have or have had any of the following?

- |                      |                           |                               |
|----------------------|---------------------------|-------------------------------|
| AIDS/HIV Positive    | Fainting Spells/Dizziness | Mitral Valve Prolapse         |
| Anemia               | Glaucoma                  | Psychiatric Care              |
| Angina/Chest Pains   | Heart Attack/Failure      | Radiation Treatments          |
| Arthritis/Gout       | Heart Murmur              | Recent Weight Loss            |
| Artificial Joint     | Heart Pace Maker          | Rheumatic Fever               |
| Asthma               | Heart Trouble/Disease     | Scarlet Fever                 |
| Breathing Problem    | Hepatitis A               | Sexually Transmitted Diseases |
| Cancer               | Hepatitis B or C          | Sinus Trouble                 |
| Chemotherapy         | High Blood Pressure       | Stents                        |
| Convulsions          | Hypoglycemia              | Stomach/Intestinal Disease    |
| Diabetes             | Kidney Problems           | Stroke                        |
| Drug Addiction       | Leukemia                  | Thyroid Disease               |
| Emphysema            | Liver Disease             | Tuberculosis                  |
| Epilepsy or Seizures | Low Blood Pressure        | Ulcers                        |
- Other: \_\_\_\_\_

**Notes (Dental Staff Use Only):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

History Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

Medical problems and allergies entered into computer by: \_\_\_\_\_

Date: \_\_\_\_\_

## Patient Dental History:

- When was your last dental visit?..... \_\_\_\_\_
- Have you had any head, neck, or jaw injuries? .....  Yes  No
- Have you had any difficult extractions in the past? .....  Yes  No

**I confirm that to the best of my knowledge this information is accurate.**

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_