BRIAN HOWE DDS
Family Dentistry

812 Coshocton Ave, Mt Vernon OH, 43050
1534 W. Church Street, Newark OH, 43055

740.393.2161
740.344.4549

Patient Information

First Name_____ Last Name _____

Patient SSN_____ Date of birth_____ Gender_____

Title _____ Previous visit to the dentist _____ Family Status ☐Married ☐Single ☐Child ☐Other

Mr/Ms/Mrs/Dr

Patient address _____

City_____ State_____ Zip code_____

Phone _____ _____ _____ _____ _____

(Home) (Work) (Mobile) (Fax) (Other)

Email _____

☐ I would like to receive communications via email

☐ I can accept text messages

Emergency contact name _____

Relationship to patient _____ Emergency contact phone number _____

How do you hear about Brian Howe DDS, Family Dentistry _____

The following is for: ☐ the patient ☐ the person responsible for payment ☐ both ☐ not applicable

Employer name _____ Phone number _____

Employer address _____

City_____ State_____ Zip code_____

Insurance Information

Name of insured _____ _____ _____

First Last Date of birth

Insured ID# _____ Insured Group # _____

Insured address _____

City_____ State_____ Zip code_____

Insured's employer _____

Insured's Employer address _____

City_____ State_____ Zip code_____

Patient's relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name _____

Insurance company's address _____

City_____ State_____ Zip code_____

☐ By checking this box,
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges, whether or not paid by insurance.

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Secondary Insurance information (if applicable)

Name of insured _____ _____ _____

First Last Date of birth

Insured ID# _____ Insured Group # _____

Insured address _____

City_____State_____Zip code_____

Insured's employer _____

Insured's Employer address _____

City_____State_____Zip code_____

Patient's relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name _____

Insurance company's address _____

City_____State_____Zip code_____

☐ By checking this box,
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
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Medical History

Indicate which of the following you have had or have at present. By checking the box, it will indicate a "YES" response, leaving it blank will indicate a "NO" response.

- ☐ Pre-Medication- Amox
- ☐ Allergy
- ☐ Allergy – Hay Fever
- ☐ Allergy - Sulfa
- ☐ Asthma
- ☐ Dizziness
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Other
- ☐ Respiratory Problems
- ☐ Stomach Problems
- ☐ Ulcers
- ☐ Ever been hospitalized (illness or injury)
- ☐ Taking weight control medication (ie Fen-phen)
- ☐ Pre-Medication- Clind
- ☐ Allergy - Aspirin
- ☐ Allergy - Latex
- ☐ Anemia
- ☐ Blood Disease
- ☐ Epilepsy
- ☐ Head Injuries
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Venereal Disease
- ☐ Subject to frequent headaches
- ☐ FEMALE: Pregnant
- ☐ Pre-Medication- Other
- ☐ Allergy – Codeine
- ☐ Allergy - Other
- ☐ Arthritis
- ☐ Cancer
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ HIV
- ☐ Mental Disorders
- ☐ Pregnancy
- ☐ Rheumatism
- ☐ Tuberculosis
- ☐ Taking dietary supplements
- ☐ FEMALE: Taking birth control pills
- ☐ Allergies
- ☐ Allergy - Erythro
- ☐ Allergy - Penicillin
- ☐ Artificial Joints
- ☐ Diabetes
- ☐ Fainting
- ☐ Heart Murmur
- ☐ Jaundice
- ☐ Nervous Disorders
- ☐ Radiation Treatment
- ☐ Sinus Problems
- ☐ Tumors
- ☐ Smoker (present or past)
- ☐ Presently being treated for any other conditions

If any conditions or alerts selected above needs further clarification, please explain :

Do you take antibiotic premedication for your dental visits? If yes, please explain

Name of physician and their specialty:

Most recent physical exam and purpose:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

List all medication, supplements, and/or vitamins taken within the last two years:

☐ By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible

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Dental History

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous dentist's name and how long have you been a patient there?

Date of most recent exam: _____

Date of most recent xrays: _____

I routinely see my dentist every : ☐ 3mos ☐ 4mos ☐ 6 mos ☐ 1 year ☐ Not routinely

What is your immediate concern?

_____

_____

Patient Name: _____ Date : _____

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Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be in advance. The practice depends upon reimbursement from patients for the cost incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental service, or any dental services performed without previous financial arrangements, must be paid in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient's examination. A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial agreements are satisfied.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ ***By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the Administration Form.**

Patient Name: _____ Date: _____

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HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this situation.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

☐ **By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the HIPAA Disclosure Form.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of Agreements and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ ***I have read the information above regarding the secured uploading of patient information to the web site for the dental practice and grant the dental practice permission to securely upload my patient information to the web site.**

Patient Name : _____ Date: _____

Patient/Guardian signature: _____