Patient Information & Health History – Page 1 Date: _____

Patient Information

☐Mr. ☐Mrs. ☐Ms. ☐Dr. First Name_____ M.I. __ Last_____
Sex: ☐Male ☐Female Birth Date:_____ Age____ Soc. Sec. #_____
Address_____ City_____ State_____ Zip_____
Home Phone (____)_____ Cell Phone (____)_____ Email_____
Driver's Lic. #_____ Emergency Contact Name_____ #(____)_____
Student: ☐Full Time ☐Part Time ☐Not Student
School Name_____ School Address_____
Marital Status: ☐Married ☐Divorced ☐Legally Separated ☐Widow ☐Single
Employed: ☐Full Time ☐Part Time ☐Retired ☐Not Employed
Do you belong to a PPO or HMO? ☐Yes ☐No
Employer_____ Business Phone (____)_____
Personal Payment Type: ☐Cash ☐Check ☐Credit Card

Referring Doctor/Pharmacy Info

Have you ever been a patient of our practice? ☐Yes ☐No
Has a family member ever been a patient of our practice? ☐Yes ☐No
Referred by:_____ Referring doctor is a: ☐Dentist ☐Specialist
General Dentist Name:_____
Preferred Pharmacy:_____ Pharmacy Phone:_____
Pharmacy Address:_____

Who will be responsible for your account?

☐Self (*if self, skip to next section*) ☐Spouse ☐Father ☐Mother ☐Other_____
First Name_____ Last Name_____ Phone (____)_____
Birth Date:_____ Soc. Sec. #_____
Address_____ City_____ State_____ Zip_____
Employer_____ Business Phone (____)_____

Spouse or other guarantor information (*if different from above*)

Relation: ☐Spouse ☐Father ☐Mother ☐Other_____
First Name_____ Last Name_____ Phone (____)_____
Birth Date:_____ Soc. Sec. #_____
Address_____ City_____ State_____ Zip_____
Employer_____ Business Phone (____)_____

 Date: _____

Primary Dental Insurance

Insured Member: First Name_____ Last Name_____

Sex: ☐Male ☐Female Birth Date:_____ Soc. Sec. #_____

Relationship to Patient: ☐Self ☐Spouse ☐Father ☐Mother ☐Other_____

Does your plan cover: ☐Dental ☐Medical ☐Both

Insured Member I.D. #_____ Group #_____

Employer Name_____

Insurance Company Name_____ Ins. Co. Phone (____)_____

Ins. Co. Address_____ City_____ State_____ Zip_____

Secondary Dental Insurance

Insured Member: First Name_____ Last Name_____

Sex: ☐Male ☐Female Birth Date:_____ Soc. Sec. #_____

Relationship to Patient: ☐Self ☐Spouse ☐Father ☐Mother ☐Other_____

Does your plan cover: ☐Dental ☐Medical ☐Both

Insured Member I.D. #_____ Group #_____

Employer Name_____

Insurance Company Name_____ Ins. Co. Phone (____)_____

Ins. Co. Address_____ City_____ State_____ Zip_____

Primary Medical Insurance

Insured Member: First Name_____ Last Name_____

Sex: ☐Male ☐Female Birth Date:_____ Soc. Sec. #_____

Relationship to Patient: ☐Self ☐Spouse ☐Father ☐Mother ☐Other_____

Does your plan cover: ☐Dental ☐Medical ☐Both

Insured Member I.D. #_____ Group #_____

Employer Name_____

Insurance Company Name_____ Ins. Co. Phone (____)_____

Ins. Co. Address_____ City_____ State_____ Zip_____

Secondary Medical Insurance

Insured Member: First Name_____ Last Name_____

Sex: ☐Male ☐Female Birth Date:_____ Soc. Sec. #_____

Relationship to Patient: ☐Self ☐Spouse ☐Father ☐Mother ☐Other_____

Does your plan cover: ☐Dental ☐Medical ☐Both

Insured Member I.D. #_____ Group #_____

Employer Name_____

Insurance Company Name_____ Ins. Co. Phone (____)_____

Ins. Co. Address_____ City_____ State_____ Zip_____

<u>Patient Health History Form</u> - Please complete the Health History so that we may provide the best possible care; the doctor will discuss the History with you prior to beginning treatment.

Patient's Name_____ Date of Birth_____

I. GENERAL INFORMATION

Sex: ☐Male ☐Female Height_____ Weight_____

Are you in good health? ☐Yes ☐No

Are you now under a physician's care for a particular problem? If so, describe:

_____

_____

Physician name and telephone#_____

Date of last physical exam_____

Has there been any change in your general health in the past year? If so, describe:

_____

_____

Have you ever had any serious illness? If so describe:

_____

_____

Have you been hospitalized or had surgery during the last 5 years? If so describe:

_____

_____

II. DO YOU HAVE OR HAVE YOU EVER HAD: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Cardiovascular disease? (heart attack, coronary artery disease, angina, chest pain, irregular heart rate or palpitations, congenital heart disease, rheumatic heart disease, murmur)
2. High blood pressure?
3. Stroke?
4. Heart surgery? (bypass or stent)
5. Pacemaker?
6. Respiratory disease? (asthma, emphysema, COPD, chronic cough, bronchitis)
7. Epilepsy or seizures?
8. Fainting or dizziness?
9. Bleeding disorder, anemia?
10. Blood transfusion?
11. Bruise or bleed easily?
12. Liver disease (jaundice, hepatitis)?
13. Kidney disease?
14. Diabetes (Type?)
15. Thyroid disease?
16. Arthritis?
17. Stomach ulcers or acid reflux (GERD)?
18. Other GI disease?
19. Glaucoma?
20. Osteoporosis?
21. Implants or joint replacements?
22. Radiation therapy?
23. Chemotherapy?
24. Sinus or nasal problems?
25. Seasonal allergies?
26. Snoring or sleep apnea?
27. Psychiatric illness?
28. Disease or medication that has depressed your immune system?
29. Organ transplant?

III. ARE YOU TAKING ANY OF THE FOLLOWING: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Antibiotics?
2. Anticoagulants or blood thinners (Coumadin, Plavix)?
3. Aspirin or ibuprofen?
4. Steroids (cortisone, prednisone, etc.)?
5. Tranquilizers, sleep aids, antidepressants, narcotics?
6. Insulin or oral anti-diabetic drugs?

Have you ever taken:

7. Diet pills?
8. Bisphosphonate bone density medications (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa)?
9. Have you ever been advised to not take a medication?
10. Please list ALL medications you are taking, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals (*please attach medications list if you run out of space*):

_____
_____
_____
_____
_____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Local anesthesia (Novocain, etc.)?
2. Penicillin or other antibiotics?
3. Sedatives, barbiturates?
4. Aspirin or ibuprofen?
5. Codeine or other painkillers?
6. Latex or rubber products?
7. Chemicals or jewelry (rash or sensitivity)?
8. Food products? Soy? Eggs?
9. Other allergies or reactions? If so, please list:

_____
_____
_____

V. FOR FEMALE PATIENTS ONLY

1. Please provide the date of you last menstrual period. _____
2. Are you pregnant, or is there any chance you might be pregnant? If so, when is your expected delivery date? _____
3. Are you nursing? _____

If you are using Oral Contraceptives, it is important that you understand that antibiotics and some other medications may interfere with the effectiveness of oral contraceptives. You may need to use an additional form of birth control for one cycle of birth control pills after a course of antibiotics or other medication is completed. Please consult with your physician.

VI. ADDITIONAL INFORMATION: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Do you smoke or chew tobacco?
   How much?_____ For how long?_____
2. Is there any past history of alcohol or chemical dependency?
3. Is there any emotional or psychiatric illness that may affect the care we provide?
4. Have you had any serious problems associated with previous dental treatment?
5. Do you have pain, clicking or popping of the jaw joint, or difficulty opening mouth?
6. Do you grind or clench your teeth?
7. Have you or an immediate family member had any problem associated with anesthesia?
8. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?
9. Do you wish to talk to the doctor privately about anything?

I understand the importance of a truthful and complete health history to assist the doctor in providing the best possible care. I have read and understand the above information.

DATE_____ PATIENT SIGNATURE (OR PARENT/GUARDIAN IF MINOR)_____

Welcome to Our Practice

Drs. Benninger, Schween, & Schmidt are pleased to welcome you to our practice. We look forward to providing you with the most modern oral surgery care available.

Financial Arrangements (Self-Pay and Insurance Patients)

We require payment in full at the time of service for anything not covered by an insurance company. This amount is your responsibility. We accept Cash, Checks, VISA, MasterCard, Discover, and Care Credit.

Insurance Instructions (Insurance Patients Only)

We file your insurance claims as a courtesy to you. Professional services are rendered and charged to you, not the insurance company. Please understand that the contract is between you and the insurance company, and payment for the services is *your* responsibility. We do not determine the amount of coverage you will receive. Your insurance company makes this determination. Any questions you may have concerning your insurance benefits should be directed to your insurance representatives. We will be happy to submit your claim for you. We reserve the right to refuse assignment of benefits for some insurance plans.

At the time of service, we will call your insurance company and get an "estimated payment" for the services rendered. The "estimated" portion that the insurance company does not pay is required at the time of service, in full. After your insurance pays, you will be billed for the amount that differs from the estimate that was made at the time of service. Should the insurance company pay more than anticipated, we will issue a refund check to you.

If we are accepting assignment of benefits (payment from your insurance company), you are required to sign the following statement prior to the appointment, even if your appointment is for a consultation:

I hereby authorize payment of benefits directly to Medina Oral Surgeons.

X _____
Signed (Patient OR Parent/Guardian if Minor)

I understand that I will be receiving a treatment plan with associated fees. I agree to be responsible for all charges for services and materials not paid by my insurance. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

I HAVE READ AND UNDERSTAND THE STATEMENTS OUTLINED ABOVE IN THE FINANCIAL ARRANGEMENTS AND/OR INSURANCE INSTRUCTIONS SECTIONS.

X _____ _____ _____
Signed (Patient OR Parent/Guardian if Minor) Relationship to Patient Date

Dr. Richard M. Benninger, Dr. Gary R. Schween, and Dr. Brian P. Schmidt
Notice of Privacy Practices

This following notice describes how health information about you may be used and disclosed and how you can get access to this information. The privacy of your health information is important to us. Please review it carefully. The notice can be downloaded and printed, or viewed online, here:

http://www.medinaoralsurgeons.com/hipaa-privacy-policy

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____(please print full name), HAVE BEEN PRESENTED WITH THE NOTICE OF PRIVACY PRACTICES, AND HAVE BEEN OFFERED A COPY OF SUCH POLICY TO KEEP FOR MY RECORDS.

_____ (PLEASE INITIAL HERE), I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PROVIDED A COPY OF THE POLICY.

-OR-

_____ (PLEASE INITIAL HERE), I HEREBY REFUSE TO ACKNOWLEDGE RECEIPT OF THE POLICY. I UNDERSTAND THAT EVEN THOUGH I MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT, I WILL STILL BE PROVIDED TREATMENT.

_____ _____
(SIGNATURE) PATIENT OR LEGAL REPRESENTATIVE (DATE)

****

I, _____(please print full name) AUTHORIZE THE OFFICE OF DRS. BENNINGER, SCHWEEN, AND SCHMIDT TO DISCUSS MY HEALTH AND/OR ACCOUNT INFORMATION WITH THE FOLLOWING PEOPLE:

SPOUSE: _____

CHILDREN: _____

PARENT: _____

OTHER: _____

_____ _____
(SIGNATURE) PATIENT OR LEGAL REPRESENTATIVE (DATE)

****

Acknowledgment of Text and Voicemail Messages

I HEREBY ACCEPT OR DENY THE OFFICE OF DRS. BENNINGER, SCHWEEN, AND SCHMIDT THE ABILITY TO LEAVE DETAILED VOICEMAIL MESSAGES AND/OR TEXT MESSAGES WITH GENERAL TREATMENT INFORMATION AND APPOINTMENT REMINDERS.

☐ I ACCEPT ☐ I DENY

_____ _____
(SIGNATURE) PATIENT OR LEGAL REPRESENTATIVE (DATE)

PATIENT ACKNOWLEDGEMENT – TELEHEALTH CONSULTATION SERVICES

Telehealth includes the use of remote communication technology to conduct virtual problem-focused evaluations to help manage oral health concerns and to determine whether immediate in-office dental treatment is required.

I have been informed that telehealth is an option during the COVID-19 pandemic to evaluate my dental health concerns, screen for dental emergencies and minimize the risk of virus transmission.

Patient Acknowledgement – Telehealth Consultation Services

I acknowledge that I wish to receive telehealth consultation services.

I understand that this telehealth consultation is for the purpose of evaluating dental pain, oral swelling, and / or treatment planning.

I understand that I may request to refuse or stop telehealth services at any time.

I understand that if at any time during or after the telehealth consultation I experience a life-threatening condition or medical emergency, I will immediately call 911 or go to the nearest emergency room.

I understand and accept that a telehealth consultation cannot replace an in-office consultation and I acknowledge that the doctor's ability to diagnose my condition could be limited by this technology. I further understand, acknowledge and accept that a virtual evaluation may not reveal conditions that might otherwise be discovered during an office visit.

I agree to provide detailed and accurate information as requested by the doctor and that this information may include photographs or videos taken by me with a mobile device.

I understand that telehealth carries technology risks and that there may be an interruption in service or lack of audio/visual quality.

I understand that the telehealth consultation may be recorded for clinical documentation and quality assurance purposes.

I understand that based on the telehealth consultation, follow up treatment may be indicated.

Patient Acknowledgement – Patient Privacy, HIPAA, and Administrative Matters

I understand that all electronic medical communications carry some level of privacy risk for the security of my health information and I understand that my doctor and my doctors staff will use good faith efforts to protect the privacy of my health information and to minimize these risks.

I understand that during the COVID-19 national public health emergency the federal government announced that it will not enforce HIPAA regulations (regarding the privacy of health records) in connection with medical and dental offices' good faith provision of medical or dental services using non-public facing audio or video remote communications services.

PATIENT ACKNOWLEDGEMENT – TELEHEALTH CONSULTATION SERVICES (CONT.)

I agree to follow any technology instructions provided by the doctor for the telehealth consultation including the use of applications that allow video chats such as FaceTime, Facebook Messenger video chat, Google Hangouts, or Skype.

I acknowledge that the telehealth consultation may involve requests for photos or videos taken with my mobile device and transmitted to the dental office through unencrypted applications.

I understand that I am responsible for any payment resulting from this consultation that is not covered by a dental insurance plan.

My typed or hand written name below acknowledges I that have read and understand this document, that I understand the information provided to me by the doctor and/or staff, and that my questions have been answered to my satisfaction.

Patient's Name Date

Legal Guardian's Name (if required) Date