## It's all about you!

Lakewood Dental Wellness

**First Name:** _____ **Last Name:** _____ **M.I.** ____ **Suffix** ____

**Preferred Name / Nickname (optional):** _____

**How did you hear about us?** Friend/family: _____ Doctor: _____
Insurance website Google Other: _____

**Occupation:** _____

**How can we help you?** Improve the appearance of my teeth/smile
Improve/maintain overall dental health
Toothache/TMJ Pain

**How have your dental experiences been in the past?**
Excellent Mediocre Frightening/Painful
If frightening, what causes this? _____
_____
What could we do to help you with this? _____
_____

**Have you had regular checkups and cleanings over the past several years?** Yes No
**Approximately when was your last cleaning?** _____
If applicable, what has kept you from visiting a dentist regularly?
Money Time Procrastination Pain/Fear Other: _____

**Why did you leave your previous dentist office?** _____
If possible, how can we improve/resolve this problem in our office?
_____

**Do any of your family members wear dentures?** Yes No
If yes, did they lose their teeth at an early age? Yes No

**Do your gums bleed when you brush?** Yes No
**How often do you brush?** _____
**Do your gums bleed when you floss?** Yes No
**How often do you floss?** _____

**Do you like your smile?** Yes No
How would you change it if you could?
_____

**What days and times are best for your appointments?** _____

# Patient Registration

**PATIENT INFORMATION:**

First Name: _____ Last Name: _____ M.I. ____

Preferred Name / Nickname (optional): _____

Name of responsible parent/guardian (if different from self): _____

Address (No. & Street): _____ APT or Suite #: _____

City, State, Zip: _____ Email address: _____

Home: _____ Cell: _____

Marital: [ ] Married [ ] Divorced [ ] Separated [ ] Single [ ] Widowed

Birthdate: _____ Social Security Number: _____

---

**PRIMARY INSURANCE INFORMATION:**

Patient's relationship to Policy Holder: [ ] Self [ ] Spouse [ ] Child [ ] Other

Name of Policy Holder (*if different from self*): _____

Policy Holder SSN (*if different from self*): _____ Birthdate (*if different from self*): _____

Employer Name: _____

***Leave blank if on Insurance Card:***

Insurance Company Name: _____

ID #: _____ Group Name: _____ Group #: _____

Address: _____ City, State, Zip: _____

---

**SECONDARY INSURANCE INFORMATION:**

Patient's relationship to Policy Holder: [ ] Self [ ] Spouse [ ] Child [ ] Other

Name of Policy Holder (*if different from self*): _____

Policy Holder SSN (*if different from self*): _____ Birthdate (*if different from self*): _____

Employer: _____ Address: _____

City, State, Zip: _____ Phone: _____

***Leave blank if on Insurance Card:***

Insurance Company Name: _____

ID #: _____ Group Name: _____ Group #: _____

Address: _____ City, State, Zip: _____

# General Informed Consent

Lakewood Dental Wellness

I, _____, consent to be a patient at 14701 Detroit Avenue Suite 720, Lakewood, OH 44107 (Lakewood Dental Wellness) and agree to a radiographic and clinical examination.

**I also understand and consent to the following:**

1. **Medical history:** I will provide a thorough and complete medical history as well as a full list of my medications with dosages. I consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.
2. **Treatment variety:** During the course of treatment, I may undergo procedures in all aspects of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, radiography, and others.
3. **Treatment longevity:** No guarantees can be made about treatment outcomes, longevity, nor prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.
4. **Treatment changes:** My treatment plan may change at any time, and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.
5. **Financial arrangements:** I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been pre-approved, I am responsible for *any* costs that my insurance does not cover.
6. **Missed appointment policy:** I will make honest attempts to keep my appointments, arrive 10-15 minutes early, and call the office at least 24 hours in advance if I cannot make my appointment time. I understand after a second missed appointment, I will be placed on a short-notice call list instead of scheduling a third appointment.
7. **Understanding your care:** I am welcome to ask questions about any and all aspects of my dental care. I will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ Patient or Guardian Signature

_____/_____/_____ Date

# Financial Policy

Lakewood Dental Wellness

We're committed to providing you with the best possible care and understand your interest in the cost of quality oral health care. Please ask if you have any questions about our fees, financial policy, or your responsibility.

**Patients without insurance:** Payments must be paid in full on the date of service.

---

**Patients with insurance:** To ensure you receive the full benefits of your coverage, we are happy to assist you in filing insurance claims, but we will not become involved in disputes between you and your insurance carrier regarding deductibles, co-payments, covered charges, secondary insurance or the usual and customary determination of fees. The insurance relationship constitutes an arrangement between the insurance company and your employer.

**Co-payments & Deductibles:** When receiving payment from your insurance company, we are legally obligated to bill you your insurance company's co-payment and/or deductible.

**Guarantees:** Even if your benefits have been verified in advance, it is NOT a guarantee of benefits to be paid. After we receive a response from your insurance company, additional payment still may be due from you. If your insurance company hasn't paid your claim in full within 45 days, the balance becomes your responsibility.

**Overpayments:** If we receive payment from your insurance company after you have paid the balance in full (causing an overpayment), you may either receive a refund or elect to have it applied to future services.

**Late Payments:** 1.5% (one and a half) will be added to your balance if not paid within 90 days

**Collection Agency:** 25% (twenty-five) Collections fee will be added to your balance if not paid within 100 days

**New patients:** If you have dental benefits but do not come prepared with your information, please provide this information within 24 hours. Non-compliance will result in the balance becoming your responsibility.

---

**Payment Options:**

- Cash, check, debit, Mastercard, Visa, Discover, American Express credit cards
- Health Savings Account (HSA) or Flexible Spending Account (FSA)
- Interest-free financing options include: My Chase Plan®, AmEx Pay it Plan it®, Care Credit card

I have read and understand the financial policy of Lakewood Dental Wellness and authorize my insurance company to make payment directly to the practice.

| _____ | _____ | _____/_____/_____ |
|---|---|---|
| Patient Name | Patient or Guardian Signature | Date |

# Patient Medical History

Although we primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems or medications could have an important interrelationship with the dentistry you will receive.

| | | | |
|---|---|---|---|
| Are you under a physician's care now? | Yes | No | If yes: _____ |
| Have you ever been hospitalized or had a major operation? | Yes | No | If yes: _____ |
| Have you ever had a serious head or neck injury? | Yes | No | If yes: _____ |
| Are you taking any medications, pills, or drugs? | Yes | No | If yes: _____ |
| Do you take, or have you taken, Phen-Fen or Redux? | Yes | No | If yes: _____ |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | Yes | No | If yes: _____ |
| Are you on a special diet? | Yes | No | If yes: _____ |
| Do you use tobacco? | Yes | No | If yes: _____ |
| Do you use controlled substances? | Yes | No | If yes: _____ |

**Women:** Are you or could you be pregnant? Yes No Nursing? Yes No Taking oral contraceptives? Yes No

**Are you allergic to any of the following?**

| | | | | |
|---|---|---|---|---|
| Aspirin | Penicillin | Codeine | Acrylic | |
| Metal | Latex | Sulfa Drugs | Local Anesthetics | Other: _____ |

**Do you have, or have you had, any of the following?**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | Yes | No | Excessive Thirst | Yes | No | Mitral Valve Prolapse | Yes | No |
| Alzheimer's Disease | Yes | No | Fainting/Dizziness | Yes | No | Osteoporosis | Yes | No |
| Anaphylaxis | Yes | No | Frequent Cough | Yes | No | Pain in Jaw Joints | Yes | No |
| Anemia | Yes | No | Frequent Diarrhea | Yes | No | Parathyroid Disease | Yes | No |
| Angina | Yes | No | Frequent Headaches | Yes | No | Psychiatric Care | Yes | No |
| Arthritis/Gout | Yes | No | Genital Herpes | Yes | No | Radiation Treatments | Yes | No |
| Artificial Heart Valve | Yes | No | Glaucoma | Yes | No | Recent Weight Loss | Yes | No |
| Artificial Joint | Yes | No | Hay Fever | Yes | No | Renal Dialysis | Yes | No |
| Asthma | Yes | No | Heart Attack/Failure | Yes | No | Rheumatic Fever | Yes | No |
| Blood disease | Yes | No | Heart Murmur | Yes | No | Rheumatism | Yes | No |
| Blood Transfusion | Yes | No | Heart Pacemaker | Yes | No | Scarlet Fever | Yes | No |
| Breathing Problems | Yes | No | Heart Trouble/Disease | Yes | No | Shingles | Yes | No |
| Bruise easily | Yes | No | Hemophilia | Yes | No | Sickle Cell Disease | Yes | No |
| Cancer | Yes | No | Hepatitis A | Yes | No | Sinus Trouble | Yes | No |
| Chemotherapy | Yes | No | Hepatitis B or C | Yes | No | Spina Bifida | Yes | No |
| Chest Pains | Yes | No | Herpes | Yes | No | StomachDisease | Yes | No |
| Cold Sores | Yes | No | High Blood Pressure | Yes | No | Stroke | Yes | No |
| Congenital Heart Issues | Yes | No | High Cholesterol | Yes | No | Swelling of Limbs | Yes | No |
| Convulsions | Yes | No | Hives or Rash | Yes | No | Thyroid Disease | Yes | No |
| Cortisone Medicine | Yes | No | Hypoglycemia | Yes | No | Tonsillitis | Yes | No |
| Diabetes | Yes | No | Irregular Heartbeat | Yes | No | Tuberculosis | Yes | No |
| Drug Addiction | Yes | No | Kidney Problems | Yes | No | Tumors or Growths | Yes | No |
| Easily Winded | Yes | No | Leukemia | Yes | No | Ulcers | Yes | No |
| Emphysema | Yes | No | Liver Disease | Yes | No | Venereal Disease | Yes | No |
| Epilepsy or Seizures | Yes | No | Low Blood Pressure | Yes | No | Yellow Jaundice | Yes | No |
| Excessive Bleeding | Yes | No | Lung Disease | Yes | No | | | |

**Have you had any serious illness not listed above?** Yes No If yes: _____

Comments: _____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

| _____ | _____ | _____/_____/_____ |
|---|---|---|
| Patient Name | Patient or Guardian Signature | Date |

# Acknowledgement of Receipt of Notice of Privacy Practices

Lakewood Dental Wellness

*You May Refuse to Sign this Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices ("HIPAA Notice of Privacy Practices" on the next two pages).

_____ _____/_____/_____

Patient or Guardian Signature Date

**Our office is not allowed** to give medical/dental information to anyone without the patient's consent.

**If you wish** to have any of your medical/dental information released to family members or friends, please list the individual(s) below:

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

---

## Office use only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices.
Receipt could not be obtained due to:

Individual refused to sign
An emergency situation prevented us from obtaining acknowledgement
Communication barriers prohibited obtaining the acknowledgement

Consent Revoked. Date/Initials: _____/_____

Lakewood Dental Wellness
14701 Detroit Ave. Suite 720 Lakewood, OH 44107
(216) 529-7181

# HIPAA NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

Please keep for your records

**You have the right to:**

- Get an electronic or paper copy of your medical record
  - *You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.*
  - *Ask us how to do this.*
  - *We will provide a copy or a summary of your health information, usually within 30 days of your request.*
  - *We may charge a reasonable, cost-based fee.*
- Ask us to correct your medical record
  - *You can ask us to correct health information about you that you think is incorrect or incomplete.*
  - *Ask us how to do this.*
  - *We may say "no" to your request, but we'll tell you why in writing within 60 days.*
- Request confidential communication
  - *You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.*
  - *We will say "yes" to all reasonable requests.*
- Ask us to limit the information we use or share
  - *You can ask us not to use or share certain health information for treatment, payment, or our operations*
  - *We are not required to agree to your request, and we may say "no" if it would affect your care.*
  - *If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.*
  - *We will say "yes" unless law requires us to share that information.*
- Get a list of those with whom we've shared your information
  - *You may ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, whom we shared it with, and why.*
  - *We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.*
- Get a copy of this privacy notice
  - *You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.*
  - *We will provide you with a paper copy promptly.*
- Choose someone to act for you
  - *If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.*
  - *We will make sure the person has this authority and can act for you before we take any action.*
- File a complaint if you believe your privacy rights have been violated
  - *You can complain if you feel we have violated your rights by contacting us using the information at the top of this page..*
  - *You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting* **www.hhs.gov/ocr/privacy/hipaa/complaints/**. *We will not retaliate against you for filing a complaint.*

---

**For certain health information, you can tell us your choices about what we share**.

If you have a clear preference for how we share your information in these situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information and/or condition with your friends and family if we believe it is in your best interest.*

*We may also share your information when needed to:*

- Lessen a serious or imminent threat to health and safety
- Provide disaster relief
- Include your information in a hospital directory
- Contact you for fundraising efforts (We may initially contact you but you may request we not contact you again)

In the following cases, we *never* share your information unless you give us written permission:

- Market purposes
- Sale of your information

- Most sharing of psychotherapy notes

**We typically use/share your health information to:**

- Treat you
  - *We can use your health information and share it with other professionals who are treating you.*
  - ***Example:*** A doctor treating you for an injury asks another doctor about your overall health condition.
- Run our organization
  - *We can use and share your health information to run our practice, improve your care, and contact you when necessary.*
  - ***Example:*** We use health information about you to manage your treatment and services.
- Bill for your services
  - *We can use and share your health information to bill and get payment from health plans or other entities.*
  - ***Example:*** We give information about you to your health insurance plan so it will pay for your services.

---

**How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- Help with public health and safety issues
  - *Preventing disease*
  - *Helping with product recalls*
  - *Reporting adverse reactions to medications*
  - *Reporting suspected abuse, neglect, or domestic violence*
  - *Preventing or reducing a serious threat to anyone's health or safety*
- Health research
- Comply with the law
  - *We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.*
- Respond to organ and tissue donation requests
  - *We can share health information about you with organ procurement organizations.*
- Work with a medical examiner or funeral director
  - *We share health information with a coroner, medical examiner, or funeral director when someone dies.*
- Address workers' compensation, law enforcement, and other government requests
  - *For workers' compensation claims*
  - *For law enforcement purposes or with a law enforcement official*
  - *With health oversight agencies for activities authorized by law*
  - *For special government functions such as military, national security, and presidential protective services*
- Respond to lawsuits and legal actions
  - *We can share health information about you in response to a court or administrative order, or a subpoena.*
- Provide you with appointment reminders (such as voicemail messages, texts, postcards, or letters)

---

**What are our responsibilities?**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing.
  - If you tell us we can, you may change your mind at any time.
  - Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

---

**Changes to the Terms of This Notice**

- We can change the terms of this notice, and the changes will apply to all information we have about you.
- The new notice will be available upon request, in our office, and we will mail a copy to you.

**Organizations**

This Notice of Privacy applies to all affiliated entities doing business at Lakewood Dental & Wellness Center.

Contact Agent: Matthew A Jurcak, DMD, Compliance Officer
14701 Detroit Ave Suite 720, Lakewood, OH 44107
Phone: (216) 529-7181
Email: office@LakewoodDWC.com

**Effective Date of this Notice: March 2, 2021**