Evanko
Dental Group of Medina

PATIENT REGISTRATION – DEMOGRAPHICS AND INSURANCE

TODAY'S DATE _____

PATIENT NAME _____
FIRST LAST MIDDLE INITIAL

PREFERRED NAME / NICKNAME _____

PATIENT IS: ☐ INSURANCE POLICY HOLDER
☐ RESPONSIBLE PARTY

PATIENT INFORMATION

ADDRESS _____ ADDRESS 2_____

CITY _____ STATE _____ ZIP _____ EMAIL _____

HOME PHONE _____ CELL PHONE _____

SEX ☐ MALE ☐ FEMALE MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

SOCIAL SECURITY # _____-_____-_____ BIRTH DATE _____ CURRENT AGE _____

REFERRED BY _____ PREVIOUS DENTIST (and location) _____

RESPONSIBLE PARTY (if someone other than the patient)

FIRST NAME _____ LAST NAME _____ MIDDLE INITIAL _____

ADDRESS_____ ADDRESS 2 _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

BIRTH DATE _____ SOCIAL SECURITY # _____-_____-_____

IS RESPONSIBLE PARTY ALSO INSURANCE POLICY HOLDER? **Y N** IF SO, PRIMARY OR SECONDARY? _____

PRIMARY DENTAL INSURANCE

NAME OF POLICY HOLDER _____ RELATIONSHIP TO PATIENT _____

POLICY HOLDER BIRTH DATE _____ POLICY HOLDER SOCIAL SECURITY # _____-_____-_____

POLICY HOLDER EMPLOYER _____ INSURANCE CO. NAME _____

EMPLOYER ADDRESS _____ INSURANCE CLAIMS ADDRESS_____

CITY,STATE,ZIP _____ CITY, STATE, ZIP _____

EMPLOYEE INSURANCE/POLICY ID # _____ GROUP # _____

SECONDARY DENTAL INSURANCE

NAME OF POLICY HOLDER _____ RELATIONSHIP TO PATIENT _____

POLICY HOLDER BIRTH DATE _____ POLICY HOLDER SOCIAL SECURITY # _____-_____-_____

POLICY HOLDER EMPLOYER _____ INSURANCE CO. NAME _____

EMPLOYER ADDRESS _____ INSURANCE CLAIMS ADDRESS_____

CITY,STATE,ZIP _____ CITY, STATE, ZIP _____

EMPLOYEE INSURANCE/POLICY ID # _____ GROUP # _____

Evanko
Dental Group of Medina

FINANCIAL POLICY

Payment for services, including deductibles and copayments, is due at the time of the service unless other arrangements have been made prior to treatment. Payments may be made using cash, check, Visa, Mastercard, Discover, or CareCredit. Any arrangements for third-party financing must be made before starting treatment.

Evanko Dental Group of Medina is exclusively in-network with Delta Dental insurance plans, however, we accept most out-of-network dental benefit plans. It is your responsibility to verify out-of-network coverage for your insurance. We are happy to submit the claims necessary to see that you receive your benefits. The insurance contract is an agreement between you and the insurance company. You are ultimately responsible for all charges. We cannot guarantee that any coverage estimated by your plan will be paid once a claim is filed.

In order to maximize your benefits, and because plans differ from carrier to carrier, and from policy to policy, our office may refer you to your carrier or your employer's benefits coordinator for assistance in understanding your plan. Please note that dental insurance is intended to cover some but not all dental care costs, and not all services are covered by your plan. You are responsible for payment of all services regardless of the payable benefit.

Checks that are returned to our office from your financial institution are subject to a $40 returned check fee. This fee covers the processing fees that are charged to our office. We would be happy to discuss our charges and how they relate to your particular situation.

If you find that you must cancel or change your appointment, we require a minimum of 24 hours notice so that we may make every effort to accommodate other patients. If proper notice is not received, a $25 fee may be charged for every appointment missed or cancelled.

Please indicate your understanding and acceptance of these financial policies by signing below.

_____ _____

PRINT Patient's name Date

_____ _____

Patient, guardian or guarantor SIGNATURE Date

Evanko
Dental Group of Medina

ADULT EXAMINATION QUESTIONNAIRE

IN ORDER TO AID IN EVAULUATING YOUR DENTAL HEALTH THOROUGHLY, PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE. THIS WILL BECOME PART OF YOUR OFFICE RECORD AND WILL BE HELD IN STRICT CONFIDENCE.

1. WHAT PROMPTED YOU TO SEEK DENTAL CARE AT THIS TIME? _____
2. HOW LONG SINCE YOUR LAST THOROUGH DENTAL EXAM? _____
3. WOULD YOU PREFER A LOCAL ANESTHETIC FOR MOST DENTAL TREATMENT? _____
4. HAVE YOU EVER USED NITROUS OXIDE (LAUGHING GAS) FOR DENTISTRY? _____
5. ARE YOU SATISFIED WITH YOUR PAST DENTISTRY? _____
6. WHOM MAY WE THANK FOR REFERRING YOU? _____
7. NAME, CITY, STATE, AND PHONE # OF YOU LAST DENTIST: _____
   _____
8. HAS ANOTHER DOCTOR RECOMMENDED THAT YOU PRE-MEDICATE WITH AN ANTIBIOTIC PRIOR TO DENTAL PROCEDURES? IF SO, WHAT ANTIBIOTIC? _____
9. HAVE YOU BEEN PRESCRIBED PAIN MEDICINE IN THE PAST YEAR? IF SO, WHAT? _____
   _____

EVANKO DENTAL GROUP OF MEDINA

RECORDS RELEASE REQUEST – FOR TREATMENT PURPOSES

DATE: _____

PREVIOUS DENTIST(S) NAME: _____

PREVIOUS DENTIST(S) ADDRESS OR LOCATION: _____

_____

PREVIOUS DENTIST(S) PHONE NUMBER: _____

PREVIOUS DENTIST(S) EMAIL ADDRESS: _____

I AUTHORIZE THE RELEASE OF DENTAL RECORDS AND MEDICAL RECORDS RELEVANT TO DENTAL TREATMENT, OR COPIES OF SUCH, AND REQUEST THEY BE TRANSFERRED TO *EVANKO DENTAL GROUP OF MEDINA*.

_____ _____

SIGNATURE OF PATIENT, PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE DATE

_____ _____

PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE RELATIONSHIP TO PATIENT

Evanko
Dental Group of Medina

HEALTH HISTORY

1. DO YOU HAVE ANY SURGICAL IMPLANTS? IF YES, PLEASE SPECIFY WHAT TYPE:

   _____

   _____
2. HAVE YOU EVER TESTED POSITIVE FOR HIV OR AIDS?
3. HAVE YOU EVER BEEN DIAGNOSED WITH TMJ PROBLEMS?
4. HAVE YOU EVER BEEN TREATED FOR PERIODONTAL DISEASE (GUM DISEASE, PYORRHEA, TRENCH MOUTH)?
5. DO YOU HAVE ANY SPECIAL NEEDS / PHYSICAL CONDITIONS WE SHOULD BE AWARE OF? IF YES, PLEASE SPECIFY:

   _____

   _____
6. HAVE YOU EVER HAD ANY JOINT REPLACEMENT SURGERY? IF YES, PLEASE SPECIFY WHAT JOINT:

   _____
7. DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

   <u>MOUTH (circle Y or N)</u>

   Y N BLEEDING, SORE GUMS
   Y N UNPLEASANT TASTE / BAD BREATH
   Y N BURNING TONGUE / LIPS
   Y N FREQUENT BLISTERS (LIPS, MOUTH)
   Y N SWELLING / LUMPS IN MOUTH
   Y N ORTHO TREATMENTS (BRACES)
   Y N BITING CHEEKS / LIPS
   Y N CLICKING / POPPING JAW
   Y N DIFFICULTY OPENING OR CLOSING JAW

   <u>TEETH (circle Y or N)</u>

   Y N LOOSE TEETH
   Y N SENSITIVE TO HOT
   Y N SENSITIVE TO COLD
   Y N SENSITIVE TO SWEETS
   Y N SENSITIVE TO BITING
   Y N FOOD IMPACTION
   Y N CLENCHING / GRINDING
   Y N SHIFTING OF TEETH
   Y N CHANGE IN BIT

ORAL HYGIENE

1. IS THERE ANYTHING YOU DON'T LIKE ABOUT THE APPEARANCE OF YOUR TEETH? _____

   _____
2. WHAT COULD WE DO TO GIVE YOU A GREAT SMILE? _____

   _____
3. DO YOU FLOSS REGULARLY? _____

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 THE PATIENT'S) HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DENAL OFFICE OF ANY CHANGES IN MEDICAL STATUS.

_____ _____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

Evanko
Dental Group of Medina

EVANKO DENTAL GROUP OF MEDINA - MEDICAL HISTORY

PATIENT NAME _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE OR MEDICATION YOU MAY BE TAKING COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY YOU WILL RECEIVE. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	Y	N	
ARE YOU UNDER A PHYSICIAN'S CARE NOW?	☐	☐	_____
HAVE YOU EVER BEEN HOSPITALIZED OR HAD A MAJOR OPERATION?	☐	☐	_____
HAVE YOU EVER HAD A SERIOUS HEAD OR NECK INJURY?	☐	☐	_____
ARE YOU TAKING ANY MEDICATION, PILLS, OR DRUGS?	☐	☐	(PLEASE LIST) _____
_____			
DO YOU TAKE (OR HAVE YOU TAKEN) PHEN-FEN OR REDUX?	☐	☐	_____
HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL, OR ANY OTHER MEDICATION CONTAINING BISPHOSPHONATES?	☐	☐	_____
ARE YOU ON A SPECIAL DIET?	☐	☐	_____
DO YOU USE TOBACCO?	☐	☐	_____
DO YOU USE CONTROLLED SUBSTANCES?	☐	☐	_____

FEMALES, ARE YOU… ☐ PREGNANT / TRYING TO GET PREGNANT? ☐ NURSING? ☐ TAKING ORAL CONTRACEPTIVES?

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ ASPIRIN ☐ PENICILLIN ☐ CODEINE ☐ ACRYLIC ☐ OTHER _____
☐ METAL ☐ LATEX ☐ SULFA DRUGS ☐ LOCAL ANESTHETICS _____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING:

AIDS / HIV POSITIVE ☐	CORTISONE MEDICINE ☐	HEMOPHILIA ☐	RADIATION TREATMENTS ☐
ALZHEIMER'S DISEASSE ☐	DIABETES ☐	HEPATITIS A ☐	RECENT WEIGHT LOSS ☐
ANAPHYLAXIS ☐	DRUG ADDICTION ☐	HEPATITIS B or C ☐	RENAL DIALYSIS ☐
ANEMIA ☐	EASILY WINDED ☐	HERPES ☐	RHEUMATIC FEVER ☐
ANGINA ☐	EMPHYSEMA ☐	HIGH BLOOD PRESSURE ☐	RHEUMATISM ☐
ARTHRITIS / GOUT ☐	EPILEPSY OR SEIZURES ☐	HIGH CHOLESTEROL ☐	SCARLET FEVER ☐
ARTIFICIAL HEART VALVE ☐	EXCESSIVE BLEEDING ☐	HIVES OR RASH ☐	SHINGLES ☐
ARTIFICIAL JOINT ☐	EXCESSIVE THIRST ☐	HYPOGLYCEMIA ☐	SICKLE CELL DISEASE ☐
ASTHMA ☐	FAINTING SPELLS / DIZZINESS ☐	IRREGULAR HEARTBEAT ☐	SINUS TROUBLE ☐
BLOOD DISEASE ☐	FREQUENT COUGH ☐	KIDNEY PROBLEMS ☐	SPINE BIFIDA ☐
BLOOD TRANSFUSION ☐	FREQUENT DIARRHEA ☐	LEUKEMIA ☐	STOMACH / INTESTINAL DISEASE ☐
BREATHING PROBLEMS ☐	FREQUENT HEADACHES ☐	LIVER DISEASE ☐	STROKE ☐
BRUISE EASILY ☐	GENITAL HERPES ☐	LOW BLOOD PRESSURE ☐	SWELLING OF LIMBS ☐
CANCER ☐	GLAUCOMA ☐	LUNG DISEASE ☐	THYROID DISEASE ☐
CHEMOTHERAPY ☐	HAY FEVER ☐	MITRAL VALVE PROLAPSE ☐	TONSILLITIS ☐
CHEST PAINS ☐	HEART ATTACK / FAILURE ☐	OSTEOPOROSIS ☐	TUBERCULOSIS ☐
COLD SORES / FEVER BLISTERS ☐	HEART MURMUR ☐	PAIN IN JAW JOINTS ☐	TUMORS OR GROWTHS ☐
CONGENITAL HEART DISORDER ☐	HEART PACEMAKER ☐	PARATHYROID DISEASE ☐	ULCERS ☐
CONVULSIONS ☐	HEART TROUBLE / DISEASE ☐	PSYCHIATRIC CARE ☐	VANEREAL DISEASE ☐
			YELLOW JAUNDICE ☐

HAVE YOU EVER HAD ANY SERIOUS ILLNESS(ES) NOT LISTED ABOVE? ☐**Y** ☐**N** IF SO, PLEASE EXPLAIN: _____

_____

Evanko
Dental Group of Medina

HIPAA COMPLIANCE PATIENT CONSENT FORM

This Notice of Privacy Practices provides information about how
we may use or disclose protected health information.

This notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent.

The terms of this notice may change. If so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with the restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment or healthcare operations.

The practice reserves the right to change the privacy policy as allowed by law.

The patient has the right to restrict the use of this information but the practice does not have to agree to those restrictions.

The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

The practice may condition receipt of treatment upon expectation of this consent.

May we phone, email or text to confirm your appointments? Yes No

May we leave a message on your answering machine or voicemail? Yes No

May we discuss your dental condition with a member of your family? Yes No

If yes, please list name of family member_____

Phone # of family member_____

Signed by: _____ Date: _____

Print Name: _____