
# Monroeville Dental
# George Trask, D.D.S.

## PATIENT REGISTRATION

Name: _____ MI:_____ Last Name:_____

DOB: _____ Sex: F M SS# _____not required for minors

Marital Status: _____ Home #_____ Cell #_____

Mailing Adress_____

Patient Employer_____ Phone #_____

Patient e-mail: _____ Referred By: _____

Hobbies: _____

## INSURANCE INFORMATION

Name of Insured: _____ DOB:_____

SS#:_____ Relationship to Insured: Self Spouse Child Other

Insurance Company_____

Insurance Adress_____Phone#_____

Employer:_____Phone#_____

## SECONDARY INSURANCE INFORMATION

Name of Insured: _____ DOB: _____

SS#: _____ Relationship to Insured: Self Spouse Child Other

Insurance Company_____

Insurance Adress_____Phone#_____

Employer: _____Phone#_____

**Monroeville Dental**
**George Trask, D.D.S.**

## RESPONSIBLE PARTY (if patient no need to complete)

Name: _____ _____ MI:_____ Last Name:_____

DOB: _____ Relationship to patient: Spouse Parent other:_____

Address: _____

Phone #: _____

Employer: _____Work #:_____

## SPOUSE INFORMATION (if needed)

Name: _____ MI:_____ Last Name:_____

DOB: _____ Phone #: _____

Address: _____

Employer: _____Work #:_____

## PARENT INFORMATION (if needed)

Name: _____ MI:_____ Last Name:_____

DOB: _____ Phone #: _____

Address: _____

Employer: _____Work #:_____

## PARENT INFORMATION (if needed)

Name: _____ MI:_____ Last Name:_____

DOB: _____ Phone #: _____

Addresss:

_____

Employer: _____Work #:_____

Time 11:55 AM | Monroeville Dental LLC | Date 10/4/2018

**Eaglesoft Medical History**

Patient Name: | Birth Date: | Date Created:

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

| | | |
|---|---|---|
| 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 | |
| Do you use tobacco? | ○ Yes ○ No | |

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

| | | |
|---|---|---|
| Other? | ☐ | If yes |
| Do you use controlled substances? | ○ Yes ○ No | If yes |

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

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

Have you ever had any serious illness not listed ○ 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.

Signature of Patient, Parent or Guardian:

X Date:_____

Monroeville Dental
George Trask, D.D.S.

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

*You May Refuse to Sign This Acknowledgement*

**I have received a copy of this office's Notice of Privacy Practices**

## Monroeville Dental Financial Policy

**FINANCIAL POLICES:** In our office we do not want the ability to pay to be an issue for our patients. We want you to feel comfortable with us, and that includes feeling satisfied with the financial agreements regarding your dental care. We accept cash, check, Visa, MasterCard, Discover and Care Credit at the time of service.

1) **We expect copayment, deductible, and treatment plan estimate at the time of service**
2) **A $50 return check fee for NSF**
3) **We require 48 notice for appointment cancellation. A $50 cancellation fee will be charged if not given.**

**Patients with Dental Insurance:** I understand that my dental insurance is a contract between myself and my insurance carrier, not between Dr. Trask and the insurance carrier. I understand that I am responsible for the full amount of all dental fees incurred. I hereby authorize payment of the dental benefits be paid directly to Monroeville Dental. Any payments received by Dr. Trask from my insurance carrier will be credited to my account or refunded to me if I have paid the dental fees incurred.

**Patient Name Print** _____

**Signature of Patient or Gradian** _____ **Date:** _____/_____/_____

MONROEVILLE DENTAL
136 North Ridge Street, Suite C
Monroeville, OH 44847

**Notice of Privacy Practices**

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATON. PLEASE REVIEW IT CAREFULLY.**

1. **Purpose:** We understand that health information about you and your health is personal and we are committed to protecting that information. We create a record of the care and services you receive at the Dental Practice in order to provide you with quality care and to comply with certain legal requirements. This Notice of Privacy Practices describes how we may use and disclose health information about you, including demographic information, that may identify you and your related health care services to carry out your treatment, obtain payment for our services, to perform the daily health care operations of this practice and for other purposes that are permitted or required by law. This notice also describes your rights to access and control your health information. We are required to abide by the terms of this Notice of Privacy Practices. **You have a right to be notified following a breach of unsecured PHI.** If a breach of your unsecured PHI, we will notify you no later than 60 days after the breach is discovered.
2. **Written Acknowledgement:** You will be asked to sign a written statement acknowledging that you have received a copy of this notice. The acknowledgement only serves to create a record that you have received a copy of this notice.
3. Changes to this Notice: We may change the terms of our Notice, at any time. The new Notice will be effective for all health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. To request revised copy, you may call our office and request that a revised copy be sent to you in the mail or you may ask for one at the time of your next appointment.
4. **How Me May Use and Disclose Health Information about You:** The following categories describe the different ways that the Health Practice may use and disclose your health information and a few examples of what we mean. These examples are not meant to describe every circumstance, but to give you an idea of the types of uses and disclosures of your health information that are not listed or described below will be made only with your written authorization. You may revoke this authorization, at any time, in writing, but it will not apply to any actions we have already taken.

**For your treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**To obtain payment for our services:** Your health information may be used and disclosed by us to obtain payment for your health care bills. For example, we may submit requests for payment to your health insurance company for the health services that you received. We may also disclose your health information as required by your health insurance plan before it approves or pays for the health care services we recommend for you. *You have the right to restrict certain disclosures of PHI to Health plans/Insurance companies if you pay out of pocket in full for the health care services.*

**For the health care operations of other health care providers:** We may also use your health information to assist another health care provider treating you with its quality improvement activities, evaluation of the health care professionals or for fraud and abuse detection of compliance. For example, we may disclose your health information to another physician to assist in its efforts to make sure it is complying with all rules related to operating a health practice.

**As required by law:** We may use or disclose your health information when we are required to do so by law.

**For abuse or neglect:** We may disclose your health information to a public health authority that is authorized by law to receive reports of child or adult abuse or neglect. In addition, we may disclose your health information if we believe that you have been a victim of abuse, neglect or domestic violence as may be required or permitted by Ohio and/or federal law.

**For military activity and national security:** When the appropriate conditions apply, we may use or disclose health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

5. **Your Rights**

   **Following is a statement of your rights with respect to your health information and a brief description of how you may exercise these rights. You have the right to inspect and copy your health information. You may inspect and obtain a copy of your health information that we maintain. The information may contain health and billing records and any other records that we use for making decisions about you.** However, under federal law, you may not inspect or copy the following records: psychology notes, information complied related with civil, criminal, or administrative actions; and

health information that is subject to law that prohibits access to health information in certain circumstances. We may deny your request to inspect your health information. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your health record. You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your health information for the purposes of treatment, payment or health care operations. You may also request that any part of your health information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request. If we agree to the requested restriction, we may not use or disclose your health information in violation of that restriction unless it is needed to provide emergency treatment or unless we otherwise notify you that we can no longer honor your request. With this in mind, please discuss any restriction you wish to request with your physician. Please request all restrictions in writing to our Privacy Officer.

**You have the right to request that we accommodate you in communication confidential health information.** We will accommodate reasonable requests, but we may condition this accommodation by asking you for information as to how payment will be handled or other information necessary to honor your request.

**You may have the right to ask us to amend your health information.** You may request an amendment of your health information as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a disagreement with us and we may respond in writing to you amending your health record.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your health information.** This right applies to disclosures for purposes other than treatment, payment of health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made pursuant to your authorizations (permission), made directly to you, to family members or friends involved in your care, or for appointment notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

**You have the right to obtain a paper copy of this notice from us.** If you would like a paper copy of this notice, please request one from our office.

6. **Disclosures for Appointment Reminders**
   We may use of disclose your health information to contact you to remind you of your appointment, by mail or by telephone. Our message will include the name of our practice or the name of our physician as well as the date and time of your appointment or a reminder that an appointment needs to be scheduled.
7. **Complaints and Privacy Contact**
   You may complain to us if you believe your privacy rights have been violated by us. To file a complaint, please contact our office 419-465-2574 or 419-465-2598. Or contact U.S. Department of Health and Human Services.