# OCEAN DENTAL

**NORMAN F. DAHL III, D.D.S., P.C**
**904 W. MAIN STREET, SUITE A BRANFORD, CT. 06405**
**(203) 483-8806 (203) 483-9922 FAX**
**www.oceandentalct.com email: dahloffice8@yahoo.com**

## MEDICAL HISTORY

*Please fill out this form as completely as possible. This information is essential for our staff to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to safely and efficiently protect your dental needs. Incorrect information can be dangerous to your health.*
*We are happy to answer any questions!*

**NAME** _____

**ADDRESS** _____

**CITY**_____**STATE**_____**ZIP CODE**_____

**PHONE (H)** _____**(W)** _____**(C)**_____

**DATE OF BIRTH**_____**SOCIAL SECURITY #**_____

**EMPLOYER**_____**EMAIL**_____

**DENTAL INSURANCE**_____**POLICY NUMBER**_____

***IF SPOUSE HOLDS DENTAL INSURANCE POLICY:***

**NAME OF SPOUSE**_____**EMPLOYER**_____

**SOCIAL SECURITY #**_____**DATE OF BIRTH**_____

**PHYSICIAN'S NAME**_____**PHONE**_____

**MEDICATIONS YOU ARE CURRENTLY TAKING**:_____

_____

_____

**LIST ANY DRUG/MEDICINE ALLERGIES**_____
_____

**DO YOU NEED ANY PREMEDICATION BEFORE DENTAL TREATMENT? YES or NO** (circle one)
**IF YES, FOR WHAT CONDITION**: _____

**ANY SERIOUS ILLNESS OR OPERATIONS IN THE LAST 5 YEARS? YES or NO** (circle one)
**IF YES, PLEASE DESCRIBE**: _____
_____

**REASON FOR YOUR VISIT TODAY?** _____

**LAST DENTAL VISIT?** _____**LAST CLEANING?** _____

**EMERGENCY CONTACT**_____**PHONE**_____

**REFERRED BY**_____

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## MEDICAL & DENTAL HISTORY

**PLEASE CIRCLE ANY OF THE FOLLOWING YOU MAY HAVE/HAD:**

AIDS
ANAPHYLAXIS
ANEMIA
ARTHRITIS
ARTIFICAL HEART VALVES
ARTIFICIAL JOINTS
ASTHMA
BACK PROBLEMS
BLOOD DISEASE
CANCER
CHEMOTHERAPY
CORTISONE
CONGENITAL HEART LESIONS
COUGH, PERSISTENT
DIABETES
DRASTIC WEIGHT LOSS
EPILEPSY
PSYCHIATRIC CARE
REPLACEMENT SURGERY, KIND? _____
RESPIRATORY DISEASE
SPINA BIFIDA
SWELLING FEET/ANKLES
TOBACCO USE
TUBERCULOSIS
VENEREAL DISEASE

EXCESSIVE BLEEDING
FAINTING
FOOD ALLERGIES
GASTRITIS / HEARTBURN
HEART MURMUR
HEART PROBLEMS
HEMOPHILIA
HERPES
HEPATITIS, TYPE: _____
HIGH BLOOD PRESSURE
HIV POSITIVE
JAUNDICE / YELLOWING OF THE EYES
KIDNEY DISEASE/MALFUNCTION
LIVER DISEASE
MITRAL VALVE PROLAPSE
PACEMAKER
PERSISTENT DIARRHEA
RADIATION TREATMENT
OSTEOPOROSIS
SKIN RASH
STROKE
THYROID DISEASE
TONSILLITIS
ULCERS/COLITIS

DO YOU HAVE ANY OTHER CONDITIONS, DISEASES OR PROBLEMS NOT LISTED ABOVE?
IF YES, PLEASE DESCRIBE:
_____
_____

**WOMEN:**
ARE YOU PREGNANT? _____NURSING? _____

TAKING BIRTH CONTROL PILLS? _____

***PLEASE NOTE: BIRTH CONTROL PILLS MAY BE RENDERED INACTIVE WHILE TAKING ANTIBIOTICS***

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## MEDICAL & DENTAL HISTORY /continued/...

**DENTAL HISTORY –**

**PLEASE CIRCLE ANY OF THE FOLLOWING YOU MAY HAVE/HAD:**

| | |
|---|---|
| ABSCESS | LOOSE TEETH |
| FOOD TRAPS | MISSING TEETH |
| BAD BREATH | PAIN AROUND EARS |
| BAD TASTES | PAIN IN JAW JOINT |
| BITE NAILS/OBJECTS | SENSITIVE GUMS |
| BLEEDING GUMS | SENSITIVE TO HOT, COLD, SWEETS |
| BLISTERS: LIP OR MOUTH | SMOKE: HOW MANY PER DAY: _____ |
| CHEW ON ONE SIDE | STAINED TEETH |
| CLENCHING/GRINDING TEETH | SWELLING, WHERE?_____ |
| COLD SORES | SLEEP APNEA / EXCESSIVE SNORING |
| CHRONIC PAIN IN A TOOTH | UNUSUAL NOISES WHEN CHEWING |

**THE INFORMATION I HAVE PROVIDED ON THIS QUESTIONNAIRE IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS INFORMATION WILL BE USED BY DR. DAHL, DR. CELLIERS AND STAFF TO HELP DETERMINE APPROPRIATE AND HEALTHFUL DENTAL TREATMENT. IF THERE ARE ANY CHANGES IN MY MEDICAL STATUS, I WILL INFORM THE ABOVE MENTIONED STAFF. I CONSENT TO DENTAL TREATMENT AND AUTHORIZE DR. DAHL, DR. CELLIERS AND STAFF TO PROVIDE MYSELF (OR DEPENDENT) WITH REASONABLE AND PROPER MEDICAL TREATMENT.**

_____ _____
**PRINT NAME** **(DATE)**

_____ _____
**SIGNATURE (PARENT OR GUARDIAN IF MINOR)** **(DATE)**

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## FINANCIAL & APPOINTMENT POLICIES

***Please read, initial, and sign that you understand each of our company's financial and appointment policies.***

_____***Insurance Eligibility and Benefits:*** Although we initially verify your insurance eligibility and benefits, your plan benefits may change without our knowledge. You are financially responsible for any balance owed due to changes in your benefits.

_____***Co-Payments:*** All applicable deductibles, co-insurance amounts, and non-covered services amounts are due at the time service is rendered.

_____***Contracted Insurance:*** As a courtesy, we file any contracted dental insurance claim so long as you provide us with the correct insurance information, a copy of the insurance card, the insured's social security number, and picture ID. You will be required to pay for your visit in full at the time of service if you are unable to provide the above named items. The benefits you receive are based on the contract between you or your employer and the dental insurance company; not our office. Some services you may need or want may not be covered by your benefit plan. Our goal is to help you achieve and maintain optimal dental care and we will not compromise your care based on restraints of an insurance company.

_____***Non-Contracted Insurance***: Payment is due in full at the time of service for patients who have a non-contracted insurance policy. We are happy to provide you with all the necessary claim forms and information to file your claim for reimbursement.

_____I authorize my insurance company or third party payer to pay directly to the office of Dr. Dahl, Dr. Celliers & staff all insurance benefits otherwise payable to me for services rendered. I authorize this office to release any information required to process my insurance claim. I authorize all claims to be filed on my or my dependents behalf. I authorize the use of my healthcare information for the purpose of obtaining payment for services and determining benefits. **This consent will remain in effect for as long as I or my dependents are a patient of record.**

_____***Deposits:*** We reserve the right to ask for a deposit in order to reserve appointments for major restorative work. Most procedures that fall within this category are root canals, crowns, bridges, partials, and/or restorative appointments that will require 1 ½ hours of time or more. The deposit is equal to half the patient's co-insurance amount for that procedure or 50% of the procedure cost.

_____***Forms of Accepted Payment:*** Cash, personal checks, Master Card, Visa, American Express, Discover and Care Credit are all acceptable forms of payment in our office. Picture ID is required in conjunction with all forms of payment except cash.

_____***Returned Checks:*** There is a $35.00 charge for all returned checks to our office. Your bank may also charge you additional fees not associated with our office.

_____***Payment Plans:*** We have partnered with Care Credit which offers several short term no-interest payment plans and long term payment plans with minimal interest. You may apply for Care Credit in our office with the assistance of a staff member, over the phone at 1-800-365-8295, or online at www.CareCredit.com

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## FINANCIAL & APPOINTMENT POLICIES /continued/…

_____***Unpaid Insurance Balances:*** Every effort is made to process your dental claim efficiently and quickly in order to calculate your co-insurance amounts for each date of service. **However, they are still only estimates based on the current information you and your dental benefit plan provided to our office. The exact amounts are not known until the claim has been paid.** You are responsible and will be required to pay for any balance amount remaining on your account after 60 days.

_____***Account Balances:*** We provide monthly statements with remaining balances on your account. Payments are due upon receipt. You may mail your payment, stop by the office, or pay over the phone with your debit or credit card. If you choose to pay by phone, you will be required to fill out a credit card authorization form and fax or email us a copy of your picture ID.

_____***Account Balances over 90 Days Old:*** Every effort is made to inform you of your account balance. Our office mails statements and makes courtesy phone calls in an attempt to collect any owed balances. We instill the help of an outsourced collection agency once we have exhausted our efforts to contact you. There is a ten (10) percent finance charge that will apply to any accrued balance. Any accounts that are sent to collections will be charged a $50.00 fee.

_____***Extension of Treatment***: We will extend emergency care **only** to patients without past due accounts. You will be required to pay for your emergency care visit in full at the time of service. We will not allow new treatment to be scheduled for patients with past due accounts.

_____***Children under the Age of 18:*** Children under the age of 18 MUST have a parent/guardian present for the entirety of their first dental visit in our office. You may elect to sign a consent form for another responsible adult to accompany them on each subsequent visit or to attend on their own if of driving age.

_____**I UNDERSTAND THAT I AM ULTIMATELY AND FULLY FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER COVERED OR NOT COVERED BY MY INSURANCE COMPANY. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BALANCE REMAINING ON ACCOUNT AFTER INSURANCE HAS PAID OR EVEN IF THE INSURANCE IS PENDING OR HAS BEEN DENIED.**

_____ _____
**PRINT NAME** **(DATE)**

_____ _____
**SIGNATURE (PARENT OR GUARDIAN IF MINOR)** **(DATE)**

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## APPOINTMENT POLICIES

____ ***Scheduling Appointments:*** Patients are seen by appointment only. Your time is reserved just for you. Same day or next day appointments will be given based upon availability and or emergency. Emergency services will be accommodated to the very best of our ability. As every effort is made to be on time for our patients, we ask that you extend the same courtesy by arriving on time for each of your appointments as well.

____ ***Confirmations:*** Our automated confirmation system will make every attempt to reach you by the telephone numbers and E-mail provided by you. It is the patient's responsibility to confirm. You will forfeit your reserved appointment time if we cannot confirm your appointment within **24 hours (1 business day)** of your scheduled time.

____ ***Cancelling Appointments:*** We require **48 hours (2 business days)** notice to make changes in your reserved appointment time. We recognize that emergencies do occur but abuse of our time could result in being dismissed from our practice. Please help us serve you better by keeping all reserved appointment times.

____ ***I understand there will be a fee ranging between $25-$75 for failed appointments***.

_____ _____
**PRINT NAME** **(DATE)**

_____ _____
**SIGNATURE (PARENT OR GUARDIAN IF MINOR)** **(DATE)**

***We will be happy to discuss any questions you may have about our Financial or Appointment policies. We hope by presenting our policies, we will avoid any misunderstanding and therefore have more time to dedicate to your dental care.***

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## *NOTICE OF PRIVACY PRACTICES & PATIENT RIGHTS*

**OUR LEGAL DUTY: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.**

**You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.**

**USE AND DISCLOSURE OF HEALTH INFORMATION: We use and disclose health information about you for treatment, payment, and healthcare operations.**
**For example:**

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

**PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you.**

**HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provide performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.**

**YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information except those described in this Notice.**

**TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.**

**PERSONS INVOLVED IN CARE: We may use or disclose health information to notify, or assist in the notification of (including identifying and locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with any opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.**

**MARKETING HEALTH-RELATED SERVICES: We will not use your health information for the marketing communications without your written authorization.**

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

**ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.**

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## *NOTICE OF PRIVACY PRACTICES & PATIENT RIGHTS/continued…/*

**NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counter-intelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.**

**APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).**

***PATIENT RIGHTS***

**ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicable do so. (You must make a request in writing to obtain access to your health information). You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $20 per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.**

**DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based handling fee for responding to these additional requests.**

**RESTRICTIONS: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).**

**ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanations how payments will be handled under the alternative means or location you request.**

**AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing, and must explain why the information should be amended). We may deny your request under certain circumstances.**

**QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact our office. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. Contact Officer: Dr. Norman F. Dahl**
**Address: 904 W. Main Street, Suite A Branford, CT. 06405 Telephone: 203-483-8806 Fax: 203-483-9922**

_____ _____
**Signature** **Name (please print)**

**Date**_____

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