Dental Center of Northwest Ohio

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Social Security #: _____ Birth Date: _____ Gender: _____ Race_____

Address: _____ Apartment # _____
Street

_____
City State Zip Code County

Phone (Home): _____ (Work): _____ Ext: _____ (Mobile) _____

E-mail_____

Responsible Party Information

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ___

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Mobile): _____

Address: _____
Street Apartment#

_____
City State Zip Code

Insurance Information

Insurance Plan Name and Address: _____

Name of Insured: _____ Social Security#_____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Number in household_____Total household income: $_____/wk $_____/mo $_____/yr.

Contact Information /Release of Information

In case of an emergency (as determined by the treating dentist), or when making confirmation calls, please contact or leave messages with the individual(s) listed below regarding my condition. I give my permission for these calls to be made and protected health information to be shared.

_____
Name Phone Number Relationship

_____
Name Phone Number Relationship

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: «RefBy_Title» «RefBy_FName» «RefBy_MI» «RefBy_Name»

Health Information

Physician Name: _____ Phone#: _____

Pharmacy: _____ Address: _____ Phone#: _____

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply

- ☐ Abnormal bleeding
- ☐ Artificial bones
- ☐ Artificial heart valve
- ☐ Asthma
- ☐ Blood transfusion
- ☐ Cancer/Chemotherapy
- ☐ Congenital heart Defect
- ☐ Diabetes
- ☐ Drugs/alcohol abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Heart surgery
- ☐ Hemophilia
- ☐ Hepatitis _____
- ☐ High Blood Pressure
- ☐ HIV & or AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Pregnancy Weeks: #_____
- ☐ Psychiatric problems
- ☐ Radiation therapy
- ☐ Rheumatic Fever
- ☐ Scarlet fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle cell disease
- ☐ Smoker
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Venereal disease
- ☐ Yellow jaundice
- ☐ Aspirin Allergy
- ☐ Codeine Allergy
- ☐ Dental anesthetics
- ☐ Erythromycin Allergy
- ☐ Latex Allergy
- ☐ Metals Allergy
- ☐ Penicillin Allergy
- ☐ Tetracycline Allergy

OTHER:

- ☐ _____
- ☐ _____

- Do you have any health problems that the Dental Center should know about that is not listed above? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Please list any medications you are currently taking: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the Dental Center of any changes in my health or medication. I also have received a copy of the Dental Center's Privacy Practices, use of Protected Health Information and Financial policies.

X _____ Date: _____
Signature of patient, parent or guardian

Treatment Consent for Services

- I grant permission to the Dental Center of Northwest Ohio, dental staff, to perform those diagnostic, preventive, or treatment services as they deem necessary for the patient named above.
- I understand that when any or all of my teeth or my child's teeth are extracted by a Dental Center staff dentist, the Dental Center is not responsible for replacing those teeth with a full or partial denture.
- I authorize the release of any information contained in this patient file that may be requested by health, welfare, social service or insurance agencies or consulting dental personnel.
- I verify that the information concerning head of household, household members, employment and household income is correct and that I meet the eligibility guidelines of the Dental Center. I will report any changes in insurance, employment or family status to the Dental Center in order to verify ongoing eligibility.
- I understand that it is my responsibility to arrive for all dental appointments at the time and date scheduled. I understand that no further appointments will be scheduled for me or my child if three appointments are missed without calling to cancel or reschedule at least 24 hours before the scheduled appointment.
- I understand that any patient less than 18 years of age is considered a minor. An adult or guardian must accompany the patient for treatment
- I agree to all the terms and conditions set forth above.

X _____ Date: _____ Relationship to Patient: _____
Signature of patient/responsible party

Financial Policy

Thank you for choosing us as your dental care provider. We are committed to giving you quality, professional and compassionate dental care. Listed below is our financial policy. You must read and sign this sheet before receiving treatment. The Dental Center of Northwest Ohio is **NOT a free office**. Please feel free to contact our business office (419-241-1644) with any questions regarding this policy.

Patients without insurance: The Dental Center of Northwest Ohio charges a reduced fixed rate fee for patients living at or below 400% of the Federal poverty level for 19 years and older. Our reduced fixed rate fees are about 50% less than the average private dental office. To qualify for our reduced rates, patients must provide proof that their yearly household income is 400% or less of the Federal Poverty Rate and photo I.D. If you are receiving payment for services from another party you will need either a notarized letter or a letter on the facilities letterhead stating the payment portion. A full exam and x-rays will be needed to complete an estimated cost of service. If proof of income/photo I.D. and/or necessary paperwork of payment is not provided at the first annual visit, full fees are charged instead of reduced fee rates. When proof of income is provided, a refund will be mailed for payments in excess of the reduced fixed rate. Payment is expected on the date of service unless prior arrangements have been made. Payment plans are available for established patients with 6 months of serviced treatment. Gradual treatment plans are available for self-pay patients. By prioritizing treatment you may complete dental work by spreading appointments and therefore payments, over time. Self-pay patients with treatment plans of $500 or more will receive a 5% discount if the fee is paid in full at the beginning of treatment. A written treatment plan and financial agreement is required.

Patients with Medicaid or a Medicaid HMO coverage: Please present you card and photo I.D. at the registration desk when requested. Insurance card and photo I.D. must be presented at every visit. Adult co-pays are due on the date of service. Cash, check or credit card is accepted for the $3.00 co-pay. Service is suspended when the co-pay balance reaches $9.00 and no arrangements have been made to pay it.

Minor patients and dependent students: Any adult or guardian accompany the minor is financially responsible for the account. Generally, fees for self-pay children 18 years and younger are $25.00 per visit plus any applicable lab fee. Adult fees are used for root canals, crowns and surgical extractions.

Patients with private insurance: Please bring all dental insurance information with you. Patients with insurance must provide proof of income as well as proof of insurance with a claims address or you will be responsible for full charges on the day of service. Your insurance may only pay a portion of the cost of treatment. Your estimated portion is due at the time of treatment. The amount collected at the time of each visit is only an estimate. This estimate is based upon information provided to us by the insurance company. Information received from the insurance company is not a guarantee of benefit or payment. Individual plan benefits, such as plan waiting periods, UCR levels and yearly maximums vary greatly from plan to plan. If the insurance company pays less than estimated, or denies the claim entirely, you will receive a statement to that effect and you will be responsible to pay the remaining balance within 10 days. If the insurance company pays more than estimated, you will be mailed a refund. Claims submitted to an insurance company but not paid become due and payable 60 days from the date of service.

Information for Insurance Claims: As a courtesy to you, our office will submit a claim to your insurance company on your behalf, but you remain responsible for all charges. If you are unable or unwilling to provide necessary information to submit your claim such as social security numbers, picture identification, or insurance information, you will be identified as a self-pay patient, and payment will be required at the time of treatment. You then can file the claim with your insurance company if you choose to do so.

Payments: All payments, co-pays and deductibles are due before start of service. For all lab cases ½ of payment must be paid on or before start of procedure. Payments for lab fees may be paid in installments but must be paid in full to receive finished product. There is a $200.00 nonrefundable lab charge for any case processed.

Method of payment: Cash, Check, Visa, MasterCard or Discover. A $25.00 charge will be applied to your account for returned checks. Refunds will be issued within 30 days of the requested date and in the form of a check regardless of how payment was received.

X _____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

dental center

No-Show Policy

Everyone deserves quality dental care and the Dental Center is here to make it happen! In order to treat all who are seeking dental care, please follow our No-Show Policy.

Keep your appointment: You are responsible to keep your appointment. We will help by reminding you by text, e-mail, and/or telephone.

Call if you cannot keep your appointment: You must call at least 24 hours ahead of time if you cannot keep your appointment. This opens up time that we can offer to another patient.

- Please call the Cancelation Phone Line: 419-930-1323.
- Breaking an appointment without a 24 hour notice, counts as a missed appointment.

Missed Appointments: Missed appointments are taken very seriously.

- If you miss one appointment, you will be documented as having missed an appointment.
- If you miss a second appointment within the same calendar year, you will be placed on "no-show status". This means any existing scheduled appointments will be canceled.
- In order to be taken off 'no-show status' and to schedule future appointments, you will be required to write a letter to the Care Manager or Clinic Manager stating the following;
    1. Why you missed the last appointment;
    2. Why you feel you need another appointment; and
    3. That you understand that you will not be able to make appointments for six months if you do not send the letter.
- If you choose not to write a letter, you will not be able to make an appointment for six months.

Please talk to any of the dental staff if you have questions about our no-show policy.

Printed name_____Signature_____Date_____