PARKWAY DENTAL

Welcome to our practice! Thank you for choosing us for your dental care. Because your dental needs are our top priority, we strive to stay up-to-date with current research, techniques and technologies. We believe in open and honest communication, and the enclosed information is provided to ensure a smooth transition to our practice.

During your initial appointment, you will meet with one of our doctors first for a comprehensive examination in which we will evaluate your teeth, your gums, and any dental x-rays. We will listen carefully to your dental concerns and work together to develop a treatment plan to meet your oral health goals. Often, and as our scheduling allows, a dental cleaning can be completed the same day; however, a more complex medical history and/or dental needs may require a second appointment.

To assist us in providing a smooth and efficient consultation, please review and complete all included forms prior to your initial appointment. Please also bring with you a list of all current medications that you are taking. We have enclosed a Release of Records form for you to request your dental records and dental x-rays from your previous provider. Your personal health information is always kept private. Please call our office two days prior to your appointment to confirm that we have received your records.
PLEASE NOTE: If previous records and/or dental x-rays are not received, we will need to take updated dental x-rays so that our doctors can complete a thorough examination. These x-rays may not be covered by your dental insurance.

It is required that you arrive 15 minutes before your scheduled appointment so that we are able to have a record established by your appointment time. If you have dental insurance, please bring with you a copy of your insurance card and a photo ID.
IMPORTANT: All patients under the age of 18 are required to be accompanied by a parent/guardian.

Broken Appointment Policy: We require 48 hour notice for all new patients who may need to cancel or reschedule an initial appointment. If you do not provide 48 hours notice, it is possible that you will not be reappointed. Established patients are required to give 24 hour notice when rescheduling or canceling appointments, or they may be charged a $40 broken appointment fee.

If you have further questions or concerns, please email us at smile@parkwaydentalhealth.com or call us at (937) 435-9110, and we will do our best to respond within 24 hours Monday - Thursday.

Welcome again, and we look forward to meeting you!

Sincerely,

Dr Potts, Dr Schamel and the Parkway Dental Team

We are complimented that you have selected us to provide dental care for you and your family.

Patient Information

Date _____ Account #_____

Patient's Full Name _____ (Last) (First) (Middle)

Address (Street)_____(City)_____(State)_____(Zip)_____

Home Ph._____Work Ph._____Birthdate_____Social Security #_____

Employer_____Occupation_____No. Years Employed _____

Spouse's Full Name _____ (Last) (First) (Middle)

Employer_____Occupation_____No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

If patient is a minor, give parent's or guardian's name:_____

Who may we thank for referring you to our office?_____

In case of emergency, who should be notified?_____Phone:_____

Responsible Party Information

*Name_____ (Last) (First) (Middle)

*Residence_____ (Street) (City) (State) (Zip)

*Mailing Address_____ (Street) (City) (State) (Zip)

How long at this address _____ *Home Phone_____ *Work Phone_____

*Social Security #_____ *Birthdate_____ Relationship to Patient _____

* IF OTHER THAN ABOVE.

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____ Ph. # _____

Do you have dual coverage? Yes ____ No ____ If yes: **Please complete the following secondary insurance information.**

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co._____ Group No. _____ Local #_____

Insurance Co. Address _____ Ph. #_____

Insured's Employer _____ Ph. #_____

To our Patients: We feel our fees are fair, usual, customary and reasonable fees for the professional services provided. If you have dental insurance, please be reminded that this does not necessarily mean that you will be reimbursed the full amount of our fee. In such instances, please understand that you remain responsible for any unpaid fee.

Request for payment of benefits from any dental insurance does authorize our office to release any information acquired in the course of your examination or treatment. We require a completed insurance form for all visits.

Payment is expected at the time of service unless other financial arrangements are made.
There will be a monthly rebilling fee on any unpaid balance over 60 days.
We reserve the right to charge for excessive failed appointments.

I have read the above statements.

Signed _____

DENTAL HISTORY

PLEASE CIRCLE

Do you have a specific dental problem? Describe _____ YES NO
Do you have dental examinations on a routine basis? Last visit _____ YES NO
Do you brush and floss on a routine basis? How often? _____ YES NO
Do your gums ever bleed? _____ YES NO
Does food catch between your teeth? _____ YES NO
Are you interested in saving your teeth? _____ YES NO
Do you ever have popping, clicking, or discomfort in the jaw joint? _____ YES NO
Do you grind your teeth? _____ YES NO
Have you ever had trouble following tooth removal? _____ YES NO
Have your past experiences in a dental office always been positive? _____ YES NO
Do you smoke or chew tobacco products? _____ YES NO
When were your last complete x-rays taken? _____
If patient is a child, do you desire your child to have complete dental services including fluoride and cavity detecting x-rays? YES NO

MEDICAL HISTORY

Name of family physician _____ Phone # _____
Are you under a physician's care now? Why? _____ YES NO
Are you taking any medications, pills or drugs? What? _____ YES NO

_____

_____

_____

Are you allergic to any medications or substances? Please check box below: _____ YES NO
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex Rubber ☐ Metal ☐ Other
Has your physician ever recommended antibiotic pre-medication for your dental visits? _____ YES NO
FOR WOMEN: Are you pregnant or trying to get pregnant? _____ YES NO
Do you take oral contraceptives? _____ YES NO

Do you now have or have your ever had any of the following? Answer all questions by checking the appropriate box.

	YES	NO		YES	NO		YES	NO
Heart Trouble/Disease	☐	☐	Lung Disease	☐	☐	Excessive Bleeding	☐	☐
Heart murmur	☐	☐	Cancer	☐	☐	Kidney Disease	☐	☐
Heart Attack	☐	☐	Diabetes	☐	☐	Epilepsy	☐	☐
Mitral Valve Prolapse	☐	☐	Stomach/Internal Disease	☐	☐	Stroke	☐	☐
Rheumatic Fever	☐	☐	Hepatitis A (Infectious)	☐	☐	Emotional Disorder	☐	☐
Heart Pacemaker	☐	☐	Hepatitis B (Serum)	☐	☐	X-ray Treatment	☐	☐
High Blood Pressure	☐	☐	Hepatitis C	☐	☐	Chemotherapy	☐	☐
Low Blood Pressure	☐	☐	Tuberculosis	☐	☐	Drug Addiction	☐	☐
AIDS or HIV+	☐	☐	Artificial Joint	☐	☐			

Do you have any high risk factors for exposure to AIDS/HIV? _____ ☐ ☐
Have you ever had any other serious illness not checked above? _____ ☐ ☐
Discuss _____

To the best of my knowledge, all of the information provided above is correct. If I have any changes in my health status or if my medicines change, I will inform the dentist and staff at the next appointment.

X _____ DATE _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

MEDICAL UPDATES (for office use only)

Date Reviewed	Update	Date Reviewed	Update

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we ***may not be allowed*** to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ **Any of the Above**

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

Date Reviewed and Signature of Patient

_____
_____
_____
_____
_____

Date Reviewed and Signature of Patient

_____
_____
_____
_____
_____

PARKWAY DENTAL

6450 Centerville Business Pkwy
Centerville, OH 45459

Records Release Request

Please complete this form and submit to your prior dental provider prior to your first appointment. Contact our office to make sure we have received your dental records before your appointment. Failure to do so may result in your appointment being rescheduled.

Date: _____

Patients Name: _____ **DOB:**_____

I hereby authorize **(name of prior dental office)** _____ you to release any information or records regarding my dental history and/or treatment to:

Parkway Dental Health
6450 Centerville Business Parkway
Centerville, OH 45459
(937) 435-9110 ph
(937) 435-0918 fx

Digital forms and x-rays can be emailed to smile@parkwaydentalhealth.com

Please apply this request to the following family members:

_____**DOB:**_____
_____**DOB:**_____
_____**DOB:**_____
_____**DOB:**_____
_____**DOB:**_____

Patients Signature: _____

PARKWAY DENTAL

Consent for Dental Photography

I _____ (Patient's name) the undersigned, do hereby authorize and consent to the use of photographs/videos/x-rays of me taken by Parkway Dental Health Professionals before, during, and after treatment. I grant them permission to reproduce, print and publish photographs taken of me in a professional publication or in the form of prints, film or slides in connection with articles and lectures dealing with the jaw or dental disorders. I specifically waive any claim for invasion of my personal privacy which might accrue to me on account of the use of such pictures without my express consent in each instance. I do consent to the use of my photographs or images or videos or x-rays for promotional purposes including but not limited to, advertising, website, social media, publicity, commercial or display of use, patient education, and in-office promotional education for Parkway Dental Health Professionals only. I further understand that if the photographs and/or images are used, my name or similar identifying information will not be used. No full face or comparable photos will be used without your additional express written authorization. I further acknowledge that my participation is voluntary and that I will not receive any compensation, financial or otherwise, with respect to the taking, use or publication of these photographs for any dental office publications. I acknowledge and agree that publication of photographs confers no rights of ownership or royalties whatsoever.

_____ (Initials) Yes, I grant consent

_____ (Initials) No, I do not grant consent

Patient's Name: _____ Date _____

Patient or Guardian Signature: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Parkway Dental Health Professionals
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