Orlosky dental

Patient Information

Today's Date:_____ E-Mail Address:_____

Name:_____ ❑ Male ❑ Female
Last First Middle Initial

I prefer to be called:_____

Date of Birth: _____/_____/_____ Age: _____ Social Security #_____

Home Address:_____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____
EXT

Emergency Contact:_____ _____ Emergency Phone: _____
Relation to Patient

Employer:_____

Employer Address:_____
Street/PO Box City State Zip

Whom may we Thank for referring you?:_____

Person Responsible for Account if other than yourself

Name:_____ _____
Last First Middle Initial Relation to Patient

Social Security # _____ Home Phone: _____

Employer:_____ Work Phone: _____
EXT

Billing Address:_____
Street/PO Box City State Zip

Primary Patient Insurance

Orlosky Dental requires a copy of your Insurace card.

Insured's Name:_____ _____
Last First Middle Initial Relation to Patient

Insured's Date of Birth: _____/_____/_____ Insured's Social Security # _____

Insured's Employer:_____ Insured's Employer Phone: _____
EXT

Insured's Address:_____
Street/PO Box City State Zip

Secondary Patient Insurance

Orlosky Dental requires a copy of your Insurace card.

Insured's Name:_____ _____
Last First Middle Initial Relation to Patient

Insured's Date of Birth: _____/_____/_____ Insured's Social Security # _____

Insured's Employer:_____ Insured's Employer Phone: _____
EXT

Insured's Address:_____
Street/PO Box City State Zip

continued on back

Dental History

Are you currently in pain? ❑ Yes ❑ No

Do you require antibiotics before dental procedure? ❑ Yes ❑ No

Have you experienced problems associated with any previous dental work? ❑ Yes ❑ No

Do you have pain/discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do your gums bleed? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

Do your teeth have mobility? ❑ Yes ❑ No

Are your teeth sensitive? ❑ Yes ❑ No

Previous dentist name: _____

Last visit date: _____

Are you happy with your smile? ❑ Yes ❑ No

If not, what would you change? _____

_____

_____

Medical History

Do you have a personal physician? ❑ Yes ❑ No Date of last visit: _____

Physician's Name: _____

Address: _____ Phone #: _____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you been told that you snore or hold your breath while sleeping or waking up gasping for breath? ❑ Yes ❑ No

Have you ever taken Fosamax, or any other Bisphosphonate? ❑ Yes ❑ No

Are you allergic to any of the following?

Y N Asprin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry/Metals
Y N Penicillin

Please list other drugs/materials that cause allergic reactions: _____

_____

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

Week#: _____ Are you nursing? ❑ Yes ❑ No

Are you taking any of the following?

Y N Acetaminophen
Y N Antibiotics
Y N Antihistamines
Y N Asprin
Y N Blood Thinners
Y N Blood Pressure Medication
Y N Cold Remedies
Y N Cholesterol Medication
Y N Digitalis/Heart
Y N Herbal Supplements/Remedies
Y N Insulin/Diabetes Drugs
Y N Nitroglycerin
Y N Recreational Drugs
Y N Steroids/Cortizone
Y N Thyroid Medicine
Y N Tranquilizers
Y N Vitamins/Minerals

You can provide the front desk staff with a list of all items you are currently taking.

Please list the names of the prescriptions, herbal remedies, over-the-counter drugs, vitamins and minerals you currently take: _____

_____

Do you or have you experienced the following?

Y N Abnormal Bleeding
Y N Alcohol Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints
Y N Artificial Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer
Y N Chemotherapy
Y N Chicken Pox
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Drug Abuse
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Fever Blisters
Y N Glaucoma
Y N Hay Fever
Y N Headaches
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes
Y N High Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Osteoporosis Paget's Disease
Y N Pacemaker
Y N Persistent Cough
Y N Psychiatric Treatment
Y N Radiation Treatment
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Steroid Therapy
Y N Stroke
Y N Thyroid Problems
Y N Tonsilitis
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced: _____

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidense and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be _____.

_____
Signature Date

PAYMENT IS DUE AT TIME OF SERVICE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____
Signature Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIVEAS HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DICLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

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 4/14/2003 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 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.

USES AND DISCLOSURES 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 you.

Healthcare Operations: We may use and disclose your health information in connection without healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your healthcare 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 an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or 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 for any reason 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 or 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 of or disclosure of your health information, we will provide you with an opportunity to object to such disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement 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 marketing communications without your written authorization.

Required by Law: We may use and 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 other possible 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.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official 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 practicably 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 the 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 us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.10 for each page, $10.00 per hour of staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request and alternative format, we will charge a cost-based fee for providing you 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 a right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, 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 aq 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: 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 this request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation 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 it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to use using the contact information listed at the end of this Notice. You may also submit a written complaint to 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 Servies.

Contact Officer: Stephen J. Orlosky D.D.S

Telephone: (330) 797-0232 Fax: (330) 797-0239

Address: 290 Canfield-Niles Road
Youngstown, Ohio 44515

Stephen J. Orlosky, D.D.S.
Orlosky Dental
290 South Canfield-Niles Road
Youngstown, Ohio 44515

CONSENT FOR USE AND DISCLOSURE OF HEATH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Work Telephone: _____

Social Security #: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we make of our protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changed may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions or our Notice, at any time by contacting:

Contact person: Stephen J. Orlosky, D.D.S
Telephone: (330) 797-0232
Fax: (330) 797- 0239
Address: 290 South Canfield-Niles Road
Youngstown, Ohio 44515

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance of this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONESNT AFTER YOU SIGN IT