peritia dental

PATIENT INFORMATION

NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME TEL # _____ CELL TEL # _____

WORK TEL # _____

EMAIL ADDRESS (We send email reminders)

_____

REFERRAL SOURCE: HOW DID YOU HEAR ABOUT US?

EMPLOYER _____ OCCUPATION _____

NAME OF SPOUSE _____ SPOUSE EMPLOYER _____

DRIVERS LICENSE # _____ STATE _____ EXP. DATE _____

WHO MAY WE CONTACT IN CASE OF AN EMERGENCY?

NAME _____ EMERGENCY TEL# _____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
POLICY HOLDER _____	POLICY HOLDER _____
DATE OF BIRTH _____	DATE OF BIRTH _____
INS. CO. NAME _____	INS. CO. NAME _____
POLICY OR SOCIAL SECURITY # _____	POLICY OR SOCIAL SECURITY # _____
GROUP # _____	GROUP # _____
EMPLOYER _____	EMPLOYER _____

MEDICAL HISTORY

PATIENT NAME:_____ **DATE OF BIRTH:**_____ **Height:**_____ **Weight:** _____

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 that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

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

☐Other If yes, please explain: _____

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

ADD/ADHD ◯ Yes ◯ No	Depression ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
AIDS/HIV Positive ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	If yes, is it treated ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Dry Mouth ◯ Yes ◯ No	If yes, is it treated ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Hepatitis C ◯ Yes ◯ No	Sensory issues ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	If yes, is it treated ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Anxiety ◯ Yes ◯ No	Epilepsy/Seizures ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	High BP ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	If yes, is it treated ◯ Yes ◯ No	Sleep Apnea ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/ Dizziness ◯ Yes ◯ No	Low BP ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Autism ◯ Yes ◯ No		If yes, is it treated ◯ Yes ◯ No	Stomach/ Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	
Blood Thinner ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Heart Attack/ Failure ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cancer/ Chemotherapy ◯ Yes ◯ No		Liver Disease ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Lung Disease Mitral ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/ Fever Blisters ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Valve Prolapse ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Trouble/ Disease ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
	Hearing Impairment ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Vision Impairment ◯ Yes ◯ No
	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
		Recent Weight Loss ◯ Yes ◯ No	Acid Reflux ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

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_____ **DATE** _____

peritia dental

PATIENT CONSENT AND AGREEMENT

I hereby give my permission to Peritia Dental LLC and their staff to do all such things as they deem necessary to diagnose, treat and care for my dental needs.

I also give my permission to Peritia Dental to furnish any insurance company obligated to me, or any welfare or relief organization, or any political subdivision to which I have applied or may subsequently apply for aid, any and all information with respect to any illness or injury, medical history, consultation, treatment or copies of such with respect to me and my family.

I understand Peritia Dental has a 24 hour cancellation policy. If I no show or cancel without 24 hours notice, I may be charged a $25 fee. I also understand if I do this more than once I may be dismissed from the practice. If I cancel a Saturday appointment without 24 hours notice or no show, I will not be allowed to schedule another Saturday appointment.

I understand and agree that even if I have dental insurance, I am personally responsible for paying for all services provided to me by Peritia Dental irrespective of whether my insurance company covers the service provided. Unless I have paid in full for all services provided to me at the time of service, I hereby authorize my insurance company to pay directly to Peritia Dental the benefits which would otherwise be payable to me. I understand and agree that even if I have dental insurance, Peritia Dental has the right to require me to pay for a portion of the dental services provided to me by Peritia Dental at the time services are rendered. This portion may be referred to as an estimated co-payer patient portion or deductible. I further understand that if the total monies paid to Peritia Dental by me and my insurance company is less than the fees for services provided by Peritia Dental I am personally responsible for making up the difference. If the total monies paid to Peritia Dental by me and my insurance company is greater than the fees for services provided by Peritia Dental the excess will be credited to my account and/or refunded to my insurance company or me. I further agree to pay for all legal and/or collection fees associated with the collection of any balance on this account(s). I understand that it is my responsibility to verify with my dental insurance company that a particular Dentist or Specialist is a participating provider in my dental plan. Peritia Dental will make a reasonable attempt to assist me in this process, but the selection will ultimately be my responsibility. I understand that my dental coverage may require me to pay a greater co pay (patient portion) if I decide to have my treatment provided by a Dentist or Specialist who is not participating in my dental plan.

I understand and agree that all clinical notes and x-rays taken remain the property of Peritia Dental If I find it necessary to obtain a copy of my records, there will be a charge for that service which I agree to pay. I understand and agree that with dental services, as with any other treatment of the body, the results are not always expected, desired or successful and that no guarantees are or can be made as to the result of any dental treatment or series of treatments.

I have read and understand this form and in signing below I indicate my agreement with same.

Signature of Patient _____ Date _____

Person Financially Responsible for this Account, if patient is a minor (under age 18),

Signature of the Patient's legal guardian: _____ Date _____

peritia dental

Meera Thunga D.D.S

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION AND RECEIPT OF NOTICE OF PRIVACY PRACTICES

SECTION A: PATIENT GIVING CONSENT.

Name: _____

Address: _____

Telephone: _____ E-mail:_____

Social Security Number: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLOWING 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 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 may make of your 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 Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

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

Contact Person: **HIPAA COORDINATOR**
Telephone: 513-805-4000
E-mail: SMILE@PERITIADENTAL.COM

Address: **205 Dayton Street, Hamilton, OH-45011**

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 mentioned above. Please understand that revocation of this Consent will not affect any action we took in reliance on 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.

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 health care operations. I have received/been offered a copy of Peritia Dental, LLC Dr. Meera Thunga, D.D.S., Notice of Privacy Practices.

Signature: _____ Date: _____

If a personal representative is signing on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

ONLY COMPLETE THIS SECTION IF REVOKING YOUR CONSENT FOR USE AND DISCLOSURE:

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

peritia dental

FOR APPOINTMENT CALL
513-805-4000

Insurance Policy

With all the recent and ongoing insurance changes taking place, it is not possible for our office staff to know the specific details of your policy. Therefore, we are asking you to contact your insurance company prior to having a procedure done, to verify this procedure is covered under your plan.

Co-Pays are due at the time of service. We will bill your insurance out of courtesy to you, yet please understand it is your responsibility to be sure you are covered for this and future visits.

We would like to make patients aware that we do not send out pre estimates on treatment unless the patient request. Our office and insurance procedure codes may vary slightly. Which means is your insurance may cover one code but our office only performs another code due to the best interest of the patient. In the insurance "world" this is consider and "upgrade" or "down grade", where a pre estimate is exactly what it states and only estimates. We will not compromise the patient's best interest just to make it financially suitable with your insurance, we have a code of ethics to follow.

By signing this, you understand that Peritia Dental is not responsible for knowing your insurance plan specifics. Peritia Dental does not accept responsibility for any estimates or claims that insurance may deny. We are contracted with your insurance to go by a fee schedule and that is what we abide by. There are no other discounts we can provide or wave once the insurance states the patient is responsible for the owed amount. If sent to collections, 30% collection cost will be added to your bill.

Patient Name: _____

Patient Signature: _____

Date: _____