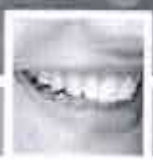
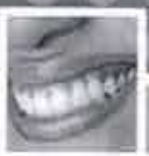
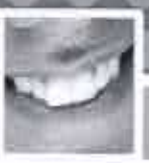
Walter D. Mick, DDS, Inc.
1561 Brice Road
Reynoldsburg OH 43068

(614)864-4618
info@MickFamilyDental.com
www.MickFamilyDental.com

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #. _____
FOR OFFICE USE ONLY

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

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

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

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Internet
☐ Newspaper ☐ School ☐ Work
☐ Other (name below):

Name of person, office, or other source referring you to our practice:

_____

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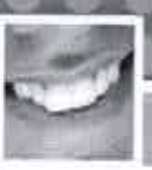

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

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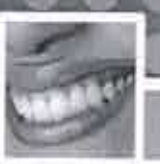
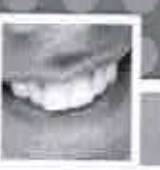

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Group Number: _____

ID Number: _____

Secondary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Group Number: _____

ID Number: _____

SSN of Secondary Insurance Subscriber: _____

Response Date: _____

Mick Family Dental Care

Walter D. Mick DDS
1561 Brice Road
Reynoldsburg, Ohio 43068
614.864.4618
www.MickFamilyDental.com

Patient Information

Patient Name:_____ Date:_____
Last First (preferred Name)

Day Phone:_____ Gender:____ Birth Date:_____

Do you have questions for Dr. Mick or his staff concerning any of the following? (Please Circle)

Invisalign (a clear alternative to braces)
Smile Makeovers
Sports Dentistry
Bruxism (grinding or clenching)

Oral Hygiene Instruction
Whitening
Bleeding Gums
Other_____

Do you have any of the following: (Please Check)

Anemia	Diabetes	Kidney Disease	Shortness of Breath
Arthritis, Rheumatism	Epilepsy	Liver Disease	Skin Rash
Artificial Heart Valve	Excessive Bleeding	Low Blood Pressure	Stroke
Artificial Joints	Fainting	Mitral Valve Prolapse	Swelling of Feet
Asthma	Gastric Reflux	Neurological Problems	Thyroid Problems
Back Problems	Glaucoma	Pacemaker	Tobacco Habit
Blood Disease	Headaches	Radiation Treatment	Tonsillitis
Cancer	Heart Murmur	Respiratory Disease	Tuberculosis
Chemical Dependent	Heart Problems	Rheumatic Fever	Tumors
Chemotherapy	Hemophilia	Psychiatric	Ulcer
Circulatory Problems	Hepatitis	Seasonal Allergies	Venereal Disease
Cortisone Treatment	High Blood Pressure	Seizures	Pregnant (currently)
Cough, Persistent	HIV/AIDS	Sinus Problems	Other
Cough up Blood	Jaw Pains	Scarlet Fever	

Have you ever had any complications following dental treatment? ____yes ____no
If yes, please explain:_____
Date of your last dental exam:_____
Have you been admitted to a hospital or needed emergency care during the past two years? ____yes ____no
If yes, please explain: _____

Name of Physician: _____ Phone_____

MEDICATIONS: Please list what you are currently taking and the reason for taking_____

_____

_____

Are you allergic to or have had a reaction to any of the following? (please circle)
Local anesthetics like Novocaine
Any Metals
Aspirin
Iodine
Latex/Rubber
Others: (please list)
Penicillin or other antibiotics Sulfa Drugs
Barbiturates, sedatives/sleeping pills

To the best of my knowledge and ability the above information is correct & true.

Signature X_____

Mick Family Dental Care
1561 Brice Road
Reynoldsburg, OH 43068
Phone: (614) 864-4618 Fax: (614-860-9225)

Privacy Consent

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent for treatment: I, with my signature, authorize Mick Family Dental Care, and any employee working under the direction of the Dentist, to provide dental care for me, or to this patient for which I am the legal guardian. This care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventive, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care or treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational need(s) as identified in the Practice Privacy Statement. I authorize the release of my PHI for the reasons to collect an unpaid account. I agree that an administrative fee may be added to my account in the event that collection proceedings become necessary.

Consent related to the Privacy Statement: I have had the chance to review the Practice Privacy Statement as part of the registration process. I understand that the terms of the Privacy Statement may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand that I have the right to request how my protected healthcare information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restriction. If it does agree to my restrictions on PHI use, it is bound by that agreement.

Consent for assignment of benefits: I consent to assign all payments for these services to this practice when appropriate, I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation(s). I understand that I am ultimately responsible for charges incurred as the result of provided healthcare services. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage, referrals, etc. I am aware that I may be responsible for all charges that are incurred.

Consent to Dental Photography: In connection with dental services, which I am receiving from either Dr. Mick or his staff, I agree and consent to allow the photographs taken before, during, and after completion of my dental treatments to be used for dental records, research, education, public relations, patient counseling, or other purposes. I further agree and consent that the photographs related to my dental care may be published and re-published, either separately or in connection with each other in dental photo albums, professional journals, or dental books.

I grant permission to you or your assignee, to telephone me at home or work to discuss matters related to my dental care.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time. If I revoke this consent, the revocation does not take affect until the practice receives it.

Patient/Guardian_____ Date_____

Name Printed_____ If not patient, relationship_____

Copy of Practice Privacy Statement signed or initiated with patient/guardian on:_____

Patient unable to sign Privacy Consent due to: _____

Revocation:
I hereby revoke the consent given above:

Patient/Guardian_____ Date_____

Name Printed_____ If not patient, relationship_____

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. This is a formal notification, as required by HIPAA (Health Insurance Portability and Accountability Act) concerning the privacy policy of this practice. It is important that all patients and staff understand the importance of guarding patient information.

II. This practice has a legal obligation to maintain all dental and medical records and information in the strictest of confidence as required by law. This means that we must safeguard patient information. We cannot release information to others without your written consent, including conversations, reminder calls, test results and other information of a confidential nature. Patient information about health care is identified as PHI (protected health information). This change in policy requires that you, the patient, identify and clarify at the time of registration or re-registration with this practice whom we can talk to, how we can leave information on your behalf, and the process for ongoing continuity of your dental care. **You can change this information at any time with either written notification or verbal notification, followed up in writing**. Changes can only impact the care or information from that point in time forward.

III. Your protected health information (PHI) is an intricate part of your medical care, and can be used or disclosed with your written consent as follows:

*For your treatment in this practice and other locations under the health care provider's immediate care. This may include any referral for services such as lab, x-rays, other diagnostic testing or treatment related to your condition or medical care needs. This may also include conversations with other health care providers.

*For obtaining payment for treatment with your identified insurance/health coverage program. This would include any documentation related to this process, including history forms, progress notes or operative notes. This would include eligibility verification, prior authorization and claim submission.

*For operations of this practice, such as enrolling with insurance programs, accounting, and compliance with federal and state laws and regulations.

*Appointment reminders/health related services with your consent identified on the registration form.

*Disclosure to your family and friends concerning any related health care information with your consent on the registration form which can modified at any time, orally, followed with written consent.

***Consent is not required for emergency care and treatment. An emergency is identified as a condition that in the judgment of the health care provider required immediate and full information for care on your behalf.**

Certain disclosures can be made without your consent, and they are as follows:

*Disclosure required by the government of law enforcement agencies.

*Information used for public health purposes, medical examiners, or for the health department for disease tracking.

*Information used for health care oversight, such as a site review by an insurance program.

*Information related to research procedures, the majority of this information is generic in nature.

*Information provided to **avoid harm** if there is a threat to patient or other safety.

*Specific government functions.

IV. Your rights with respect to your protected health information.

*The right to request limits on the uses and disclosure at registration or any time during your care.

*The right to choose how we send this information to you, including an alternate address.

* The right to see and obtain copies of this information, but there may be copy and postage fees.

*The right to get a listing of who we have made disclosures to about your PHI.

*The right to correct and update your file through an amendment process if appropriate.

V. This practice reserves the right to modify or change this Privacy Statement and process at any time. Revision to Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice. An updated Privacy Notice will be posted in the office within 60 days of the revision.

VI. If you have a concern or complaint about how your protected health information is being used from this time forward.

*Contact the Privacy Officer and complete a complaint form for review and discussion.

*If you are not satisfied with this response, you may report the practice to:

Office of Civil Rights
Regional Manager
Department of Health & Human Services
233 N Michigan Ave, Suite 240
Chicago, IL 60601

Patient Signature on receipt of Privacy Notice:_____ date _____

Patient unable to sign due to:_____ date_____

Patient refused to sign / witness:_____ date_____