

ROBERT GREEN, D.D.S., INC.
133 WEST HULL DRIVE
DELAWARE, OH 43015
740-363-3871

IMPORTANT NOTICE REGARDING
OFFICE POLICIES
AND
DENTAL BENEFITS

Welcome to our office. Review and completion of the forms attached will allow our office to best serve your dental needs. Please note we are a paperless office, so your signature will be acquired electronically at the time of your visit, for all documents requiring signature. We look forward to your visit!

Prior to your scheduled appointment, please contact your dental insurance company for complete details of benefits. It is important for you as a patient to know your benefit coverage and to know what is and what is not covered.

Deductibles and co-insurance are only estimated and these estimates are collected at the time of service.(Please Note: If no dental insurance, payment is due in full at the time of service.)

Due to OSHA standards, we advise all parents that children can not be brought back to the operatories during your dental appointment. This is for the safety of your child. Children who are old enough to sit in our waiting room without parental guidance, may do so. Please take this policy into consideration when making your appointment.

Please be advised, **during office hours** our phones can get very busy. If after several attempts you can not reach us and you feel it is urgent, please call the emergency numbers, Dr. Green 740-815-8103 or Dr. Pawlecki 614-404-2981.

Normal Office Hours:	Monday – Wednesday	8:00am – 5:00pm
	Thursday	8:00am – 8:00 pm
	Lunch	11:30am – 1:00pm
	Friday	8:00am – 12:00pm
	Saturdays(limited)	8:00am– 12:00pm

PATIENT REGISTRATION AND INSURANCE INFORMATION

(PLEASE PRINT)

Date: _____

Patient:

First Name Initial Last Name Preferred Name

Patient Street Address _____ City _____ State/Zip _____

Patient Home Phone: _____ Patient Work _____ Cell Phone: _____

Patient Sex: M F Single Married Widowed Separated Divorced (Child) Weight: _____

Patient Birth Date: _____ Patient Social Security #: _____

We confirm recall appointments by e-mail 2 weeks in advance. We confirm all appointments using an automated system starting 48 hours prior to your appointment.

Patient E-mail: _____

Who is responsible for this account? _____

Are they a Patient? Y N Relationship to Patient? _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insurance ID#: _____ Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Phone Number: _____ Group Number: _____

Phone Number: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured ID#: _____ Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Phone Number: _____ Group Number: _____

Phone Number: _____

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

Whom may we thank for referring you? _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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
 Other If yes, please explain: _____

- Do you have, or have you had, any of the following?
- | | | | |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
| | | | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> 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 _____

Robert Green D.D.S., Inc.

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Dental Practice Covered By This Notice

This Notice describes the privacy practices of Robert Green D.D.S., Inc. ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

How to Contact Us/ Our Privacy Official

If you have any questions or would like further information about this Notice, you can either write to or call the Privacy Official for our Dental Practice:

Privacy Official for Dental Practice:	Robert E. Green D.D.S.
Dental Practice mailing address:	133 W. Hull Drive, Delaware, Ohio 43015
Dental Practice email address:	rgreendds@greendentaldelaware.com
Dental Practice phone number:	(740) 363- 3871

Information Covered By This Notice

This Notice applies to health information about you that we create or receive and that identifies you. This Notice tells you about the ways we may use and disclose your health information. It also describes your rights and certain obligations we have with respect to your health information. We are required by law to:

- ⌚ maintain the privacy of your health information;
- ⌚ give you this Notice of our legal duties and privacy practices with respect to that information; and
- ⌚ abide by the terms of our Notice that is currently in effect.

Our Use and Disclose of Your Health Information Without Your Written Authorization

Common Reasons for Our Use and Disclosure of Patient Health Information

Treatment. We will use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, voicemail, or email.

Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

Less Common Reasons for Use and Disclosure of Patient Health Information

The following uses and disclosures occur infrequently and may never apply to you.

Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

Law Enforcement Purposes. We may disclose patient health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

Coroners, Medical Examiners and Funeral Directors. We may disclose patient health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

Organ, Eye and Tissue Donation. We may use or disclose patient health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

Research Purposes. We may use or disclose patient health information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

Serious Threat to Health or Safety. We may use or disclose patient health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

Specialized Government Functions. We may disclose patient health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

Workers' Compensation. We may disclose patient health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

Your Written Authorization for Any Other Use or Disclosure of Your Health Information

We will make other uses and disclosures of health information not discussed in this Notice only with your written authorization. You may revoke that authorization at any time in writing. Upon receipt of the written revocation, we will stop using or disclosing your health information for the reasons covered by the authorization going forward.

Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

Access. You may request to review or request a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

Amend. If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

Restrict Use and Disclosure. You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception. If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

Confidential Communications: Alternative Means, Alternative Locations. You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information for the six years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We will charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

Receive a Paper Copy of this Notice. You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

We Have the Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice (including any updates) is in the top right-hand corner of the Notice.

To Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the U.S. Department of Health and Human Services Office for Civil Rights.

The privacy of your health information is important to us. We will not retaliate against you in any way if you choose to file a complaint.

Robert Green D.D.S., Inc.

**ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")**

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

Patient Name

Patient Signature (obtained electronically in office)
OR

Date

Signature of Personal Representative (obtained electronically in office)

Authority of Personal Representative to Sign for Patient (check one):

Parent Guardian Power of Attorney Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

- ___ An emergency prevented us from obtaining acknowledgement.
- ___ A communication barrier prevented us from obtaining acknowledgement.
- ___ The individual was unwilling to sign.
- ___ Other: _____

Robert Green D.D.S., Inc.
133 W. Hull Drive
Delaware, Ohio 43015
Phone (740) 363-3871
Fax (740) 369-6616

Patient Financial Responsibility

The office of Robert Green D.D.S., Inc. has a tradition of a trusting patient/doctor relationship. Periodically, we feel it is our responsibility to communicate our office policies and procedures to our patients. Please read the following information. We ask that you sign and return the letter to confirm your understanding of our policies.

Account Maintenance:

Any account 90 days past due with no payment or patient communication is eligible to be turned over for collection. Statements will be sent monthly to patients with outstanding balances. Payment is due at time of receipt.

Appointments:

We feel it is the patient's responsibility to record the date and time of their scheduled appointment. Recall appointments will be confirmed by email. We will attempt to confirm all appointments by phone the day before scheduled service. Scheduled appointments, which can not be kept, require 24-hour notice. Failure to provide 24-hour notice can result in a charge of \$25.00. Non-office hour emergency appointments can result in an after office hour charge.

Divorce Decrees:

This office is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult. Payment of outstanding balances is expected prior to separation of accounts.

Insurance:

It is the patient's responsibility to provide us with current insurance information. (Your employer and insurance company should provide this information to you.):

Insurance Company Name, Address and Phone Number

Employer Name, Address, Insurance Group Name and Number

Coverage information to include deductible, maximum amount of coverage, the beginning month the insurance company uses to reset benefits, and the % of coverage for each service type and whether it should be applied against the deductible.

Having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. As a service to our patients we file your insurance at the time of service. If we are unable to collect on your insurance after two attempts due to invalid or outdated information we will discuss the situation with you. At this time you can provide us payment and collect your own insurance or provide us the necessary current information and agree to pay a \$5.00 service fee for each additional filling there after.

Many insurance companies reimbursement for posterior composites (white/tooth colored) fillings is at the same level of benefit as an amalgam (silver) restoration for the same tooth. The additional financial responsibility is the patients.

Our policy is to attempt to estimate your insurance coverage at the time of service based on benefit information obtained from your insurance company. We expect payment of insurance deductibles and copays at the time of service. Any over estimations of deductibles and copays will be credited to the patients account and will be refunded at the patient's request, or when we review accounts for credit balances.

We will attempt to submit a pre-determination of benefits for major dental procedures at the request of the patient or if required by the insurance company. These provide an estimate of insurance coverage and patient responsibility from the insurance company.

Thank you for your business. We feel these policies and procedures allow us to provide you the professional services you deserve.

I have read the Financial Policy. I understand and agree with this Financial Policy.

X

Date:

Signature (obtained electronically in office)

Robert Green, D.D.S., Inc.
133 West Hull Drive
Delaware, OH 43015
740-363-3871

The following form needs signed and dated if you are unable to be present at a scheduled appointment for your son or daughter.

I give my permission for the doctors and staff of Robert Green DDS Inc. to treat my son/daughter.

[] Check this box if this applies to all future appointments for as long as parent or guardian is financially responsible.

Signature (obtained electronically in office)

Date

Child's name _____
