Dr. Everett Wu

20925 Lorain Rd, Fairview Park OH 44126 440.331.6116

Patient Registration and Health History

Date ______________________

Name ________________________________ **Spouse** ________________________________

Address ____

City ________________________________ **State** _____________ **Zip Code** _____________

PRIMARY Phone _________________________ **SECONDARY Phone** _________________________

Birth Date ___________________ **Sex** M F **Marital Status** S M D W

Social Security Number ______________-___________-______________

Email ____

Present Dentist ____ **Last Visit** _____________

Physician ____ **Phone** _________________

Employer ____

I authorize office staff to leave a detailed voicemail regarding upcoming appointments and financial or account information YES NO

PRIMARY DENTAL INSURANCE

Insurance Company ____

Member ID or Social Security # ____

Group/Account # ________________________________ Phone Number ____________________

Policy Holder (Guarantor) ____________________________ Date of Birth ____________________

Place of Employment ____

Relationship to Patient Self Spouse Child Other

SECONDARY DENTAL INSURANCE

Insurance Company ____

Member ID or Social Security # ____

Group/Account # ________________________________ Phone Number ____________________

Policy Holder (Guarantor) ________________________________ Date of Birth ________________

Place of Employment ____

Relationship to Patient Self Spouse Child Other

DENTAL HISTORY

Why did you seek dental treatment at this time?
□ Pain □ gum trouble □ routine checkup
□other ______________________________
Have you had any illness or complications associated
With any previous dental treatment/anesthesia? Y N

What dental treatment(s) have you had?
□ fillings □ extractions □ root canals
□ orthodontics □ gum treatment
Do you clench your teeth during the day or night? Y N

MEDICAL HISTORY

Have you been under the care of a medical doctor during the past two years?........ Y N
Are you taking or have you been taking any medicine or drugs during the past two years, including aspirin?........ Y N
Are you allergic to or made sick by penicillin, aspirin, codeine or any other medications? If yes........ Y N
Please name ______________________________
Have you ever had any excessive bleeding requiring special treatment?........ Y N
When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath or because you are very tired?........ Y N
Do your ankles swell during the day?........ Y N
Do you ever wake up from sleep, short of breath?........ Y N
Do you have any disease, condition or problem not listed?........ Y N
Do you smoke? Cigarettes Pipe Cigars How many per day? ______________________________

WOMEN
are you pregnant now?........ Y N
Are you practicing birth control?........ Y N
Do you anticipate becoming pregnant?........ Y N

Have you had any of the following?

Heart failure	Y N	Emphysema	Y N	Aids	Y N
Heart disease or attack	Y N	Chronic bronchitis	Y N	Hepatitis A (infectious)	Y N
Angina pectoris	Y N	Cough	Y N	Hepatitis B (serum)	Y N
High blood pressure	Y N	Tuberculosis	Y N	Liver disease	Y N
Heart murmur	Y N	Asthma	Y N	Yellow jaundice	Y N
Rheumatic fever	Y N	Hay fever	Y N	Blood transfusion	Y N
Congenital heart lesions	Y N	Sinus trouble	Y N	Drug or alcohol abuse	Y N
Scarlet fever	Y N	Allergies or hives	Y N	Hemophilia	Y N
Artificial heart valve	Y N	Diabetes	Y N	Venereal disease	Y N
Mitral valve prolapse	Y N	Thyroid disease	Y N	Cold sores	Y N
Heart pacemaker	Y N	X-ray or cobalt treatment	Y N	Genital herpes	Y N
Heart surgery	Y N	Chemotherapy	Y N	Epilepsy or seizures	Y N
Artificial joint	Y N	Arthritis	Y N	Fainting	Y N
Anemia	Y N	Rheumatism	Y N	Nervousness	Y N
Stroke	Y N	Cortisone medicine	Y N	Psychiatric treatment	Y N
Kidney trouble	Y N	Glaucoma	Y N	Sickle cell disease	Y N
Ulcers	Y N	HIV	Y N	Bruise easily	Y N
Cancer	Y N	Blood Thinners	Y N	Pre-med	Y N

*****PLEASE LIST ALL MEDICATIONS*****

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I hereby authorize release of any information to physicians, dentists or third parties, related to insurance claims which may be considered necessary.

Patient Name ______________________________ Date ______________

SIGNATURE ______________________________ DATE ______________

HIGH POINT PERIODONTICS

DENTAL IMPLANTS

OFFICE POLCY

PLEASE READ EACH PARAGRAPH AND INITIAL PRINT SIGN AND DATE WHEN DONE

We strive to deliver the finest care possible. We appreciate the trust in the confidence you have placed in us, we value you as a patient and will be happy to answer any questions you may have.

The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

Please note: Payments are due in full at the time of service unless prior financial arrangements are made. For your convenience, we accept Cash, Check, Visa, Master Card and Care Credit.

We also offer a 3-month payment plan (With a signed financial agreement, credit card and social security number on file)

We require $500.00 deposit upon all Implant appointments when scheduled.

Initial ______________

Insurance: As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance **estimate** to you; however, it is **not a guarantee** that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.

- All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. I authorize the release of any information concerning my (or my child's) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefit
- We require that you pay the deductible, co-payment and co-insurance, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, or CareCredit at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Initial ______________

HIGH POINT PERIODONTICS
DENTAL IMPLANTS

Missed Appointments/Cancellation Policy:

Once an appointment has been made, please remember that this time has been reserved specifically for you. We ask that in the event of you needing to cancel or reappoint the scheduled time please give us 24-hour notice. Initial therapy or surgical appointment cancellations with less than 24 hours' notice will require a down payment to hold the next appointed time. A new appointment cannot be made without the down payment. The down Payment will apply to the surgical appointment unless another cancellation is/was made within surgical window in which you forfeit the down payment.

Initial ____________

Collection Policy: Balances over 90 days and several attempts to get a hold of a patient regarding their accounts, will be turned over to a collection agency of our choice. In the event of a default account, we do not charge interest, but you will be responsible for the collection cost and attorney fees.

Initial ____________

Communications with you: By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us. We or our agents may call by telephone regarding your account. You agree that we may place such calls using an automatic dialing/announcing device. You agree that we may make such calls to a mobile telephone or other similar device. You agree that we may, for training purposes or to evaluate the quality of our service, listen to and record phone conversations you have with us.

Initial ____________

Consent: I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Patient /Parent Signature ______________________________ **Date** ____________

Patient / Parent Name Printed ______________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this acknowledgement

I,____ have been offered and received, if
Print name
desired, a copy of the Notice of Privacy Practices for High Point Periodontics.

____
Print name

____
Signature

____
Date

FAMILY SHARING

I authorize High Point Periodontics to use and disclose the protected health information to

____ (individual seeking the information).
Print name of Spouse, Significant other, Guardian Family Member/Friend

Contact phone number:
____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement count not be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgment
_____An emergency situation prevented us from obtaining acknowledgment
_____Other (Please Specify)

____

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 your 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 us using the contact information listed at the end of this Notice. You also may 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 Services.

FAIRVIEW

Lorain Rd.

Fairview Park, OH 44126

440-331-6116

GREEN

1600 E. Turkeyfoot Lake Rd.

Green, OH 44312

330-253-3198

HIGH POINT PERIODONTICS

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 THIS 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 4/14/03, 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 the 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 to you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our 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 health 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 or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment 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 or 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 the possible victim of other 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 this 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 $0.05 for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your 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 the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, 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 a 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 or 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).