HIGH POINT PERIODONTICS
1600 EAST TURKEYFOOT LAKE RD.
AKRON(GREEN), OH 44312
330-253-3198

PATIENT REGISTRATION

DATE: _____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE _____

BIRTHDATE: _____ AGE: _____MALE_____ FEMALE_____

SINGLE: _____ MARRIED: _____ DIVORCED: _____ WIDOW/ER _____

CELL #/HOME_____EMAIL: _____

EMPLOYER: _____ OCCUPATION: _____

SOCIAL SECURITY #_____

Pharmacy Name & location

_____

WHO MAY WE THANK FOR REFFERRING YOU TO OUR OFFICE?

_____

Have we treated any of your family members or friends?

_____

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

PARENT OR GUARDIAN NAME: _____

PHONE #_____ BIRTHDATE: _____

SOCIAL SECURITY #_____EMAIL: _____

ADDRESS IF DIFFERENT FROM CHILD: _____

CITY: _____ STATE: _____ ZIP: _____

PRIMARY DENTAL INSURANCE:

MEMBER NAME: _____

SS# OR ID#_____ DATE OF BIRTH: _____

ADDRESS IF DIFFERENT FROM PATIENT: _____

CITY: _____ STATE: _____ ZIP: _____

RELATIONSHIP TO PATIENT: _____

EMPLOYER: _____

INSURANCE COMPANY: _____

GROUP #_____ PHONE#_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SECONDARY DENTAL INSURANCE:

MEMBER NAME: _____

SS# OR ID#_____ DATE OF BIRTH: _____

ADDRESS IF DIFFERENT FROM PATIENT: _____

CITY: _____ STATE: _____ ZIP: _____

RELATIONSHIP TO PATIENT: _____

EMPLOYER: _____

INSURANCE COMPANY: _____

GROUP #_____ PHONE#_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

I understand that High Point Periodontics will file claims with my insurance company as a courtesy. I understand charges for services provided to me are ultimately my financial responsibility.

Signature: _____Date: _____

DENTAL HISTORY

What is your primary dental concern? _____

_____

How often do you have your teeth cleaned? _____

Do you use an electric toothbrush? Y N How many times a day do you brush? _____

Floss _____

Have you noticed any of the following (please circle) bleeding gums - loose teeth - mouth odors- bad taste – shifting teeth – sensitivity to hot/cold – clenching – grinding – pain- dry mouth - other _____

Have you had previous periodontal treatment? Y N If yes, what type of treatment & when

_____

Have you had orthodontic treatment(braces)? Y N If yes, When _____

MEDICAL HISTORY

Are you currently under the care of a physician other than regular checkups? Y N

If yes, what for?

_____

PLEASE CIRCLE ALL THAT APPLY

Heart disease	STD	Asthma
Tuberculosis	HIV+/AIDS	Bleeding problems
Heart attack	Osteoporosis	Sinus trouble
Clotting issues	Migraines	Hepatitis
Stroke	Cancer	Arthritis
Kidney trouble	Chemo	Psychiatric Care
Angina Pectoris	Radiation	Transfusions
Drug Abuse	Alcohol Abuse	Bruising
Pace Maker	Anemia	Cortisone
Liver Disease	Ulcers	Epilepsy
Sinus problems	Blood thinners	Parkinson's
Lung trouble	Diabetes	High Blood Pressure
Low Blood Pressure	Thyroid disease	COPD
Anorexia	Bulimia	Cold sores/fever blisters

Artificial Joints (knee, hip) Do you pre-medicate? Y N

Do you smoke cigarettes, a pipe, vape or chew tobacco? Y N

If yes, what and how much per day? _____

Women

Are you pregnant? Y N Are you nursing? Y N Are you taking birth control pills ? Y N

Medical History cont.

Please list ALL medications
(prescription & over the counter)

_____ _____

_____ _____

_____ _____

_____ _____

Please list ALL drug allergies

_____ _____

_____ _____

_____ _____

_____ _____

Please list any other SIGNIFICANT information regarding your medical history:

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my medical status.

Signature _____ **Date**_____

Our office is committed to meeting or exceeding the standards of Infection Control Mandated by OSHA, The Ohio State Dental Board and the ADA.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

HIGH POINT PERIODONTICS
1600 East Turkeyfoot Lake Rd.
Akron (Green), OH. 44312
330-253-3198

(you may refuse to sign this acknowledgement)

I have received and reviewed a copy of the Notice of Privacy Practices for High Point Periodontics.

Print Name: _____

Signature: _____ Date: _____

Please list any family member, friend or other person we may disclose your health information to:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

EVERETT WU, D.M.D., M.S.D.

Periodontics - Implants

1600 East Turkeyfoot Lake Road • Green, OH 44312
330-253-3198

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 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 our health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or 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: 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 our 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 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 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 voice mail 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.___ for each page, $___ 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 past 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).

Amendment Communication: You have the right to request that we communicate with you about your health information by alternative means or to an 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.

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.

Contact Person: Carolyn - Office Manager

Telephone: 330-253-3198 Fax: 330-253-9812

Address: 1600 East Turkeyfoot Lake Rd., Green, OH 44312