



EASTPOINT
DENTAL

Robert A. George, D.D.S.
Jason A. Kahan, D.D.S.

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.

Our commitment at the office of Dr. Robert A. George and Dr. Jason Kahan is to serve our patients with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your dental needs it may be necessary to share information with other Health Care Providers/Business Associates. The following are examples of instances where information may be shared.

- During treatment, we may find it necessary to seek a second opinion, refer you to a specialist, speak to a family member or a family physician due to other health related issues that may affect your dental care needs.

Our office is committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with a written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law.

If you have any questions or comments regarding your Protected Health Information feel free to contact our **Compliance Officer, Carol M. Smith at 614-755-2275 ext. 5.**

I have read and understand the above Notice of Privacy Practices. This form must be presented upon your first visit with our office.

Full Name (Parent or Legal Guardian)

Signature (Parent or Legal Guardian)

Date

Dental Registration and History

PATIENT INFORMATION:

Date

SS/HIC/Patient ID #

Last Name First Name M.I.

Address

City State Zip

E-mail Address

Sex M F Age

Birthdate

Married Widowed Single
 Minor Separated Divorced
 Partnered for _____ years

Patient Employer/School

Occupation

Employer/School Address

Employer/School Phone

Spouse's Name

Birthdate SS #

Spouse's Employer

Whom may we thank for referring you?

PHONE NUMBERS:

Home Phone Cell Phone

Work Spouse Work

Best time and place to reach you?

IN CASE OF EMERGENCY, CONTACT

(Specify someone who does not live in your household.)

Name Relationship

Cell Phone Work Phone

DENTAL INSURANCE:

Who is responsible for this account?

Relationship to Patient

Insurance Company Group #

Is patient covered by additional insurance? YES NO

Subscriber's Name

Birthdate SS #

ASSIGNMENT AND RELEASE:

I certify that I, and/or my dependent(s), have insurance coverage with

Name of Insurance Company(ies)

and assign directly to (doctor name)

all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date Relationship to Patient

DENTAL HISTORY:

Reason for your visit today?

Former Dentist City/State

Date of last dental visit last dental X-rays

Place a mark on "YES" or "NO" to indicate if you have had any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Food collection between the teeth | <input type="checkbox"/> Orthodontic treatment |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Foreign objects | <input type="checkbox"/> Pain around ear |
| <input type="checkbox"/> Blisters on lips or mouth | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Periodontal treatment |
| <input type="checkbox"/> Burning sensation on tongue | <input type="checkbox"/> Gums swollen or tender | <input type="checkbox"/> Sensitivity to cold |
| <input type="checkbox"/> Chew on one side of mouth | <input type="checkbox"/> Jaw pain or tiredness | <input type="checkbox"/> Sensitivity to heat |
| <input type="checkbox"/> Cigarette, pipe or cigar smoking | <input type="checkbox"/> Lip or cheek biting | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Sores or growths in your mouth |
| <input type="checkbox"/> Fingernail biting | <input type="checkbox"/> Mouth pain, brushing | <input type="checkbox"/> Do you floss? |
| | | <input type="checkbox"/> Do you brush? |

HEALTH HISTORY:

Patient Name _____

Physician's Name _____

Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, cand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramin). YES NO

Place a mark on "YES" or "NO" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> YES <input type="checkbox"/> NO	Epilepsy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Respiratory Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Anemia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Fainting or dizziness	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rheumatic Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO
Arthritis, Rheumatism	<input type="checkbox"/> YES <input type="checkbox"/> NO	Glaucoma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Scarlet Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO
Artificial Heart Valves	<input type="checkbox"/> YES <input type="checkbox"/> NO	Headaches	<input type="checkbox"/> YES <input type="checkbox"/> NO	Shortness of Breath	<input type="checkbox"/> YES <input type="checkbox"/> NO
Artificial Joints	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Murmur	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sinus Trouble	<input type="checkbox"/> YES <input type="checkbox"/> NO
Back Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Skin Rash	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bleeding abnormally, w/extractions or surgery	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis Type _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	Special Diet	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blood Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Herpes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stroke	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO	High Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Swollen Feet or Ankles	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chemical Dependency	<input type="checkbox"/> YES <input type="checkbox"/> NO	Jaundice	<input type="checkbox"/> YES <input type="checkbox"/> NO	Swollen Neck Glands	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chemotherapy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Jaw Pain	<input type="checkbox"/> YES <input type="checkbox"/> NO	Thyroid Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Circulatory Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tonsillitis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Congenital Heart Lesions	<input type="checkbox"/> YES <input type="checkbox"/> NO	Liver Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tuberculosis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cortisone Treatments	<input type="checkbox"/> YES <input type="checkbox"/> NO	Low Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tumor or growth on head or neck	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cough, persistent or bloody	<input type="checkbox"/> YES <input type="checkbox"/> NO	Mitral Valve Prolapse	<input type="checkbox"/> YES <input type="checkbox"/> NO	Ulcer	<input type="checkbox"/> YES <input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Nervous Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Venereal Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Emphysema	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pacemaker	<input type="checkbox"/> YES <input type="checkbox"/> NO	Weight Loss, unexplained	<input type="checkbox"/> YES <input type="checkbox"/> NO
		Psychiatric Care	<input type="checkbox"/> YES <input type="checkbox"/> NO		
		Radiation Treatment	<input type="checkbox"/> YES <input type="checkbox"/> NO		

Do you wear contact lenses? YES NO

WOMEN:

Are you pregnant? YES NO Due Date _____ Are you nursing? YES NO
Taking birth control pills? YES NO

MEDICATIONS:

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____ Phone _____

ALLERGIES:

- Aspirin
- Barbiturates (Sleeping Pills)
- Codeine
- Iodine
- Latex
- Local Anesthetic
- Penicillin
- Sulfa
- Other

UPDATES: (TO BE FILLED IN AT FUTURE APPOINTMENT)

Has there been any change in your health since your last dental appointment? YES NO

For what conditions? _____

Are you taking any new medications? YES NO

If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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For what conditions? _____

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Patient's Signature _____ Date _____

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