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:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette, pipe or cigar smoking
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection between the teeth
- ☐ Foreign objects
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain or tiredness
- ☐ Lip or cheek biting
- ☐ Loose teeth or broken filings
- ☐ Mouth breathing
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth
- ☐ Do you floss?
- ☐ 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	☐ YES ☐ NO	Epilepsy	☐ YES ☐ NO	Respiratory Disease	☐ YES ☐ NO
Anemia	☐ YES ☐ NO	Fainting or dizziness	☐ YES ☐ NO	Rheumatic Fever	☐ YES ☐ NO
Arthritis, Rheumatism	☐ YES ☐ NO	Glaucoma	☐ YES ☐ NO	Scarlet Fever	☐ YES ☐ NO
Artificial Heart Valves	☐ YES ☐ NO	Headaches	☐ YES ☐ NO	Shortness of Breath	☐ YES ☐ NO
Artificial Joints	☐ YES ☐ NO	Heart Murmur	☐ YES ☐ NO	Sinus Trouble	☐ YES ☐ NO
Back Problems	☐ YES ☐ NO	Heart Problems	☐ YES ☐ NO	Skin Rash	☐ YES ☐ NO
Bleeding abnormally, w/extractions or surgery	☐ YES ☐ NO	Hepatitis Type _____	☐ YES ☐ NO	Special Diet	☐ YES ☐ NO
		Herpes	☐ YES ☐ NO	Stroke	☐ YES ☐ NO
Blood Disease	☐ YES ☐ NO	High Blood Pressure	☐ YES ☐ NO	Swollen Feet or Ankles	☐ YES ☐ NO
Cancer	☐ YES ☐ NO	Jaundice	☐ YES ☐ NO	Swollen Neck Glands	☐ YES ☐ NO
Chemical Dependency	☐ YES ☐ NO	Jaw Pain	☐ YES ☐ NO	Thyroid Problems	☐ YES ☐ NO
Chemotherapy	☐ YES ☐ NO	Kidney Disease	☐ YES ☐ NO	Tonsillitis	☐ YES ☐ NO
Circulatory Problems	☐ YES ☐ NO	Liver Disease	☐ YES ☐ NO	Tuberculosis	☐ YES ☐ NO
Congenital Heart Lesions	☐ YES ☐ NO	Low Blood Pressure	☐ YES ☐ NO	Tumor or growth on head or neck	☐ YES ☐ NO
Cortisone Treatments	☐ YES ☐ NO	Mitral Valve Prolapse	☐ YES ☐ NO		
Cough, persistent or bloody	☐ YES ☐ NO	Nervous Problems	☐ YES ☐ NO	Ulcer	☐ YES ☐ NO
		Pacemaker	☐ YES ☐ NO	Venereal Disease	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO	Psychiatric Care	☐ YES ☐ NO	Weight Loss, unexplained	☐ YES ☐ NO
Emphysema	☐ YES ☐ NO	Radiation Treatment	☐ YES ☐ 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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