David Fulks DDS
17 Norton Road
Columbus, Ohio 43228
(614) 870-3337
(614) 614-870-3339 fax

MEDICAL EVALUATION

Name:	Birth Date:	Age:	Weight:	Height:
Emergency Contact:	Relationship:		Phone:	
Primary Physician:	Last Visit Date:		Phone:	
Specialist Physician(s):	Reason for Specialist:			

1) Do you suffer or have you been treated for ANY of the following? (Check any that are applicable.)

Cardiovascular	**X**	**Nervous System**	**X**	**Respiratory**	**X**	**Endocrine**	**X**
CAD (angina, heart attack)		Seizures/Epilepsy		COPD		Thyroid Disorders	
Heart Failure (weak heart)		Depression or Panic Attacks		Emphysema		Diabetes Mellitus – HbA1c:__	
High Blood Pressure		Psychosis or Mania		Chronic Bronchitis		Immune Disorder	
Low Blood Pressure		Multiple Sclerosis		Asthma		Pregnant (Due Date:)	
Arrhythmias (irregular beat)		Headaches/Migraine		Sinus/Hay Fever		Breast Feeding	
Congenital Heart Defect		Dementia		**Miscellaneous**		**Excretory**	
Valve Disease or Murmur		Physical/Mental Impaired		Cancer		Liver Disorder	
Artificial Heart Valve		Infections		Radiation/Chemotherapy		Kidney Disorder	
Stroke or TIA		Hepatitis		Joint Replacements		Bladder Disorder	
Bleeding Problems		HIV/AIDS		Organ Transplants		Ulcers or GERD	
Blood Cell Disorders		Tuberculosis		Inner Ear Surgery		Intestinal Problems	

2) Please list ANY **SURGERIES** or medical conditions that are not listed in the table above:

3) Emergency Department visit or any overnight hospital stay in the past 5 years? **Y / N**
4) Are you taking any bone/calcium medications (Fosamax, etc.) or Bisphosphonates? **Y / N**
5) Do you have an allergy or reaction to pain medications, antibiotics, or Ibuprofen? **Y / N**

6) Have you EVER received IV/Conscious Sedation? **Y / N** General Anesthetic? **Y / N** Any Complications? **Y / N**
7) Do you have a history of sleep disorders or apnea? **Y / N** Do you take any medications to help you sleep? **Y / N**
8) Do you smoke? packs/day _____ **Y / N** Do you drink alcohol? Drinks/week _____ **Y / N**

9) Do you have any blood work drawn regularly? **Y / N**
10) Do you have trouble swallowing pills? **Y / N**
11) Do you have a history of substance abuse? **Y / N**
12) Do you have any physical limitations to exercise? **Y / N**

13) Please list ALL allergies to medications, foods or any other substances:

14) Please list ALL medications you are currently taking - including non-prescription and herbal products:

MEDICATION LIST

Patient Name: _____ Date: _____

DRUG	DOSE (mg)	FREQ.	REASON FOR USE	ACTION/CLASS

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Patient Information

Date _____ Patient Name _____

Home Phone _____ Cell Phone _____

Address _____

Email Address _____

Social Security # _____ Date of Birth _____

Emergency Contact _____ Relationship _____

Home Phone _____ Cell Phone _____

Whom may we thank for referring you to our office? _____

Medical Insurance Company_____

Address _____

City _____ State _____ Zip Code _____

Insurance Company Phone _____

Subscriber Name _____

Member ID _____

Subscriber SSN _____ Date of Birth _____

Relationship to Subscriber _____

Employer _____

Employer Phone _____ Employer ID _____

Dental Insurance Company_____

Address _____

City _____ State _____ Zip Code _____

Insurance Company Phone _____

Subscriber Name _____

Member ID _____

Subscriber SSN _____ Date of Birth _____

Relationship to Subscriber _____

Employer _____

Employer Phone _____ Employer ID _____

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Patient Consent

I, _____, consent to be a patient at the above named office

Print Patient Name

and agree to a clinical examination. **I also understand and consent to the following:**

1. I will provide a thorough and complete medical history, supply a full list of my medications with dosages and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history. I understand that failure to disclose a complete medical history could lead to a poor clinical outcome or be life threatening in some cases.
2. No guarantees can be made about treatment outcomes, restoration longevity or prognosis. I understand that any branch of medicine, including dentistry, can involve unanticipated results.
3. My treatment plans may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.
4. I am welcome to ask questions about any aspects of my dental care and will request information if I am unsure or need more information. I am responsible for clarifying any aspects of my treatment that are unclear.
5. I authorize photos, slides, x-rays, or any other viewing of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes. However, my identity will not be revealed to the general public without my permission.

_____ _____

Signature of Patient or Guardian Date

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Appointment Responsibilities

Appointment Reminders

You will also receive a text or email 3 days prior to your appointment. You will then receive a phone call to confirm your appointment. Please reply to confirm or change it accordingly. If you prefer to receive a phone call instead of text or e-mail, please inform us and we would be happy to mark you off the list.

Missed Appointments

Please notify us at least 48 hours in advance to change or cancel your appointment. We have reserved an appointment time specifically for your needs. Failure to arrive to your appointment without notification will result in a booking fee to reschedule your next appointment. We reserve the right to dismiss you from our practice if you fail to arrive to 3 appointments without notice.

If you have any questions, please feel free to ask us as we are here to help you.

_____ _____

Signature of Patient/Guardian Date

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Financial

Before we begin your treatment, we will explain all charges. Our office coordinator will work with you to make taking care of your account as convenient and comfortable as possible. Payment for services is due at the time services are rendered. We accept, cash, check, MasterCard, Visa, American Express, and Discover credit cards. For those patients who wish to make monthly payments, we offer CareCredit, a line of credit arranged through GE Capital. Application for CareCredit can be made in the office or prior to your visit. Please contact our office for details.

In the event that you fail to pay for services rendered your account may be turned over for collection to Choice Recovery. You will be held responsible for the collection costs.

Insurance

We are a preferred provider for most dental insurance policies, both traditional and ones offered through the State of Ohio. For insured patients, payment for services includes your insurance deductible on your first visit and the percentage that your insurance company does not cover each visit.

We ask that you bring a completed insurance form to your first visit, along with your insurance card(s). Please understand that dental insurance is a contract between the patient and the insurance carrier, and not between the insurance carrier and the dentist.

Although we are anxious to help you receive your maximum allowable benefits, please remember that you are responsible for all fees incurred. We are happy to extend the courtesies of processing all claims for you and accepting the assignment of benefits. However, due to insurance changes and new guidelines, we can only wait a maximum of 60 days for all payments to be received. At 45 days, we will contact you with the number of your insurance company so that you may contact them. If we still have not received insurance reimbursement within 14 days, you will be billed for the outstanding balance.

_____ _____

Signature of Patient/Guardian Date

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly or indirectly.
* Obtain payment from third-party payers.
* Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

****

****

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

_____

Date Initials Reason

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

This office is 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 took effect April 14, 2003 and will remain in effect until we replace it.

This office reserves 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 health care 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 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.

-Person 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 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 a correctional institution or law enforcement official having lawful custody or protected health information or 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 view or receive 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. You will be charged 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, you will be charged $0.25 for each page, $8.00 per hour for staff time and to locate and copy your health information, and postage if you would like 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 our office or 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 prior to 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.

-Restrictions: 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).

-Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or 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 would like 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 contact us by using the 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 Officer:

Telephone:	(614) 237-3781	Fax:	(614) 237-4519
E-mail:	fulksfamilydental@gmail.com		
Address:	2607 East Main Street		
	Columbus, Ohio 43209		

Pharmacy Information

Patient Name and DOB: _____

Pharmacy Name: _____

Pharmacy Address:

_____

_____

Pharmacy Phone Number:

_____

_____