Dr. Scott S. Whitney, DMD
440.838.5550 swhitney@whitneydentistry.com
7000 Town Centre Drive, Suite 100, Broadview Heights, OH 44147

WHITNEY FAMILY DENTISTRY

Patient Information

Our practice graciously welcomes new patients and truly appreciates your recommendations and referrals. Our growth is largely attributed to patient referrals, which we consider to be the greatest compliment. The quality of dentistry we aspire to on a daily basis has served our patients many years and is the reason for their referrals.

Patient Contact

Name _____ _____ _____ _____
LAST MIDDLE FIRST TITLE

Address _____ _____ ____ _____
STREET CITY STATE ZIP

_____ _____ _____
HOME PHONE MOBILE PHONE WORK PHONE

SSN _____ Birth Date _____ Status ☐☐ ☐☐☐☐
M / F S M D W

Email _____

Referring Doctor _____ Referring Patient _____

Primary Insurance

Subscriber _____ Phone _____
(EMPLOYEE)

Address _____ _____ ____ _____
STREET CITY STATE ZIP

SSN _____ Birth Date _____ _____
RELATION TO PATIENT

Employer _____ Phone _____
COMPANY

Address _____ _____ _____ _____
STREET CITY STATE ZIP

Insurance _____ Phone _____
PROVIDER

Address _____ _____ _____ _____
STREET CITY STATE ZIP

Group Number _____ Member Number _____

Responsible Party

Name _____ Phone _____

Relationship to patient _____ Signature _____

Patient Name _____

Date ☐☐ / ☐☐ / ☐☐☐☐

Secondary Insurance

Subscriber _____ Phone _____
(EMPLOYEE)

Address _____ _____ ____ _____
STREET CITY STATE ZIP

SSN _____ Birth Date _____ _____
RELATION TO PATIENT

Employer _____ Phone _____
COMPANY

Address _____ _____ _____ _____
STREET CITY STATE ZIP

Insurance _____ Phone _____
PROVIDER

Address _____ _____ _____ _____
STREET CITY STATE ZIP

Group Number _____ Member Number _____

Confidential Dental History

Reason for visit _____

_____

Last Dental Visit _____ Last Dental Cleaning _____

Work done at last visit _____

How often do you visit the dentist? _____

How often do you brush teeth? _____

How often do you floss? _____

Do you have current dental problems? ☐ No ☐ Yes, please describe _____

_____

Sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Biting ☐ Chewing

Please describe _____

	Y / N		Y / N		Y / N
Do your gums bleed/hurt?	☐ ☐	Previous Oral Surgery?	☐ ☐	Jaw clicking or popping?	☐ ☐
Have you lost any teeth?	☐ ☐	Periodontal Treatment?	☐ ☐	Jaw pain?	☐ ☐
Have any loose teeth?	☐ ☐	Bite plate or mouth guard?	☐ ☐	Satisfied with teeth appearance?	☐ ☐
Do you get food trapped?	☐ ☐	Serious injury to mouth?	☐ ☐	Nervous about treatment?	☐ ☐
Previous Orthodontics?	☐ ☐	Difficulty chewing?	☐ ☐	Previous bad experience?	☐ ☐

Please explain _____

_____

Patient Name _____

Date ☐☐ / ☐☐ / ☐☐☐☐

Confidential Medical History

Y / N

☐ ☐ Have you been under the care of a medical doctor during the last two years?

If yes, please describe _____

☐ ☐ Have you taken and medication or drugs during the last two years?

Current medication/purpose _____

Past medication/purpose _____

☐ ☐ Have you taken and medication or drugs during the last two years?

Current medication/purpose _____

Past medication/purpose _____

☐ ☐ Are you aware of any allergic/adverse reaction to any medication or substance?

If so, what? _____

☐ ☐ Have you been hospitalized during the last five years?

If yes, why _____

☐ ☐ Have you lost or gained more than 10 pounds during the last year?

Indicate with an X which of the following you have now or have had in the past:

☐ Heart condition	☐ Chronic obstructive pulmonary disease	☐ Hay fever	☐ Fever blisters
☐ Chest pain	☐ Special/restricted diet	☐ Latex sensitivity	☐ Blood transfusion
☐ Congenital heart disease	☐ Artificial joints	☐ Allergies/Hives	☐ Hemophilia
☐ Heart murmur	☐ Kidney trouble	☐ Sinus trouble	☐ Sickle cell disease
☐ High blood pressure	☐ Ulcers	☐ Chronic cough	☐ Easy bruising
☐ Mitral valve prolapse	☐ Diabetes	☐ Epilepsy/Seizures	☐ Yellow jaundice
☐ Artificial heart valve	☐ Thyroid problems	☐ Nervous anxiety	☐ Alcohol abuse
☐ Heart pacemaker	☐ Glaucoma	☐ Fainting/Dizzy spells	☐ Substance abuse
☐ Rheumatic fever	☐ Contact lenses	☐ Neurological disorder	☐ Radiation therapy
☐ Arthritis/Rheumatism	☐ Emphysema	☐ Hepatitis A/B	☐ Chemotherapy therapy
☐ Cortisone medication	☐ Tuberculosis	☐ VD	☐ Tumors
☐ Swollen ankles	☐ Asthma	☐ AIDS/HIV	☐ Psychiatric care
☐ Stroke		☐ Cold sores	☐ Psychological care

Any disease/condition not listed above? _____

Women: ☐ Pregnant ☐ Nursing ☐ Oral contraceptives

Y / N

Adults: Do you or have you taken any medication for Osteoporosis (eg. Fosamax, Boniva, Actonel) ☐ ☐

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider to release pertinent information and I will notify this office of any changes regarding my health and/or medication.

Signature _____ Date _____

PATIENT/PARENT/GUARDIAN

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WHITNEY FAMILY DENTISTRY

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 (04/14/03), 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 voice mail messages, postcards, or letters).

Patient Name _____

Date ☐☐ / ☐☐ / ☐☐☐☐

Patient Consent Form

Consent for use and disclosure of health information

SECTION A: PATIENT GIVING CONSENT

Name _____ _____ _____ _____

LAST MIDDLE FIRST TITLE

Address _____ _____ _____ _____

STREET CITY STATE ZIP

SSN _____

SECTION B: TO THE PATIENT (Please read the following statements carefully)

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our **Notice of Privacy Practices** before you decide whether to sign this **Consent**. Our notice provides a description of your treatment, payment activities, and health care operations, of the uses and disclosures we make of your protected health information, and of other important matters about your protected health information. A copy of our **Notice of Privacy Practices** accompanies this **Consent**. We encourage you to read it carefully before signing this **Consent**.

We reserve the right to change our **Notice of Privacy Practices.** Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our **Notice of Privacy Practices** at the administration desk.

Right to Revoke: You will have the right to revoke this **Consent** at any time by giving us written notice of your revocation to Whitney Family Dentistry. Please understand that revocation of this **Consent** will not affect any action we took in reliance on this **Consent** before we received this revocation, and that we may decline to treat you or continue treating you if you revoke this **Consent**.

Signature:

I, _____, have had full opportunity to read and consider the contents of this **Consent** and your **Notice of Privacy Practices.** I understand that, by signing this Consent form, I am giving Whitney Family Dentistry use and disclosure of my protected health information, payment activities and health care operations.

Signature _____ Date _____

If this consent is signed by a personal representative on behalf of the patient, please complete the following information:

_____ _____

REPRESENTATIVE NAME RELATIONSHIP TO PATIENT

You may request and are entitled to a copy of this Consent Form after you sign it.

This form will be retained in your personal folder.