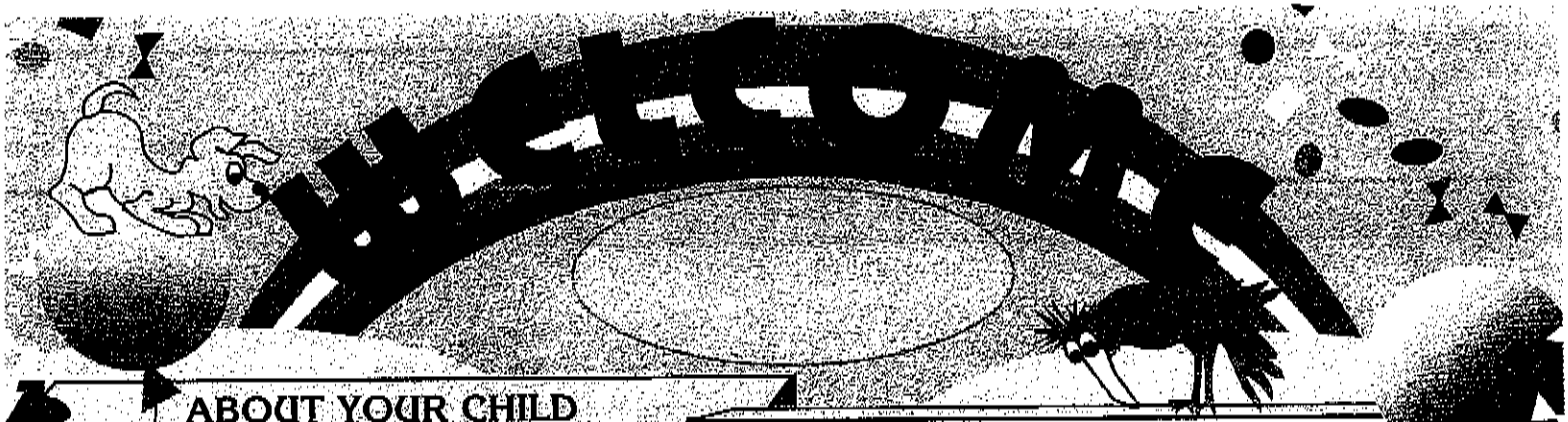

ABOUT YOUR CHILD

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Name: _____

Nickname: _____

Birthdate: _____ ☐ Male ☐ Female
Month Day Year

Social Security #: _____

Special interests, sports or hobbies: _____

_____

_____

Home Address: _____

_____
Apt./Condo # City State Zip Code

Home Phone: _____

Referred by: _____

ABOUT YOU

Your Name: _____

Social Security #: _____

Relationship to child: _____

Your home phone and address, if different from child's _____

Home phone _____

Address _____

_____
Apt./Condo # City State Zip Code

Occupation: _____

Employer: _____

Work phone: _____ Ext. _____

Beeper/Car phone: _____

DENTAL INSURANCE COMPANY

Primary Insurance

Insurance Co.: _____

Address: _____

Phone #: _____

Group #: _____

Insured's Name: _____

Relationship to child: _____

Insured's Social Security #: _____

Birthdate: _____

Employer: _____

Secondary Insurance

Insurance Co.: _____

Address: _____

Phone #: _____

Group #: _____

Insured's Name: _____

Relationship to child: _____

Insured's Social Security #: _____

Birthdate: _____

Employer: _____

Has your child been to the dentist before? ☐ Yes ☐ No

If yes, the approximate date of last visit: _____

Are there any dental problems that you are aware of at present? ☐ Yes ☐ No If yes, please explain: _____

_____

Does your child brush his/her teeth daily? ☐ Yes ☐ No

Please rate your child's oral health. ☐ Good ☐ Fair ☐ Poor

Is your child currently under the care of a physician? ☐ Yes ☐ No

Child's physician: _____

Phone #: _____

The approximate date of last visit: _____

Please rate your child's mental health. ☐ Good ☐ Fair ☐ Poor

Is your child allergic to any drugs? ☐ Yes ☐ No

If yes, please list: _____

Is your child taking any prescription drugs? ☐ Yes ☐ No

If yes, please list: _____

Does your child need to be premedicated before dental treatment? ☐ Yes ☐ No

Please circle

Y N Heart Murmur

Y N Heart problems of any kind

Y N Convulsions/Epilepsy

Y N Cancer

Y N Diabetes

Y N Rheumatic Fever

Y N HIV/AIDS

Y N Hemophilia

Y N Bleeding problems of any kind

Y N Hearing Impairment

Y N Hyperactive

Y N Any Operations _____

_____

Y N Any stays in hospital _____

_____

Are there any medical conditions or problems relating to your child that need further explanation?

☐ Yes ☐ No

If yes, please list: _____

_____

In the event of an emergency, who should we contact?

Name: _____ Relationship: _____

Phone: _____ Phone #2: _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services that my child may need.

The Parent or Guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

Signature of Parent or Guardian _____ **Date** _____

Thank you for filling out this form completely. It will enable us to give your child the best dental care possible. If you or your child have any questions, please feel free to ask us at any time.

Chart #: KE0014
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
Gender: Female Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____ _____
Street Apartment #

_____ _____ _____
City State Zip Code

Health Information

Date of Last Dental Visit: 03/02/2011 Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date: _____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____ Apartment #
Street

_____ State Zip Code
City

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Dental History Form

Why have you come to the dental office today?

_____

_____

Are you having dental pain or discomfort at this time? Yes No

Your overall dental health is: Good Fair Poor

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Approximately when was your most recent dental visit? _____

Have you ever been told by a previous dentist or physician that you require an antibiotic premedication prior to dental visits? Yes No

Do you have or have you had:

Frequent toothaches: Yes No
Pain to biting or chewing: Yes No
Sensitivity in any of your teeth to hot or cold: Yes No
Periodontal (gum) disease: Yes No
Gums that bleed with brushing or flossing: Yes No
Orthodontic treatment (braces): Yes No
Difficulty in opening or closing your jaw / pain or discomfort in your jaw joint (TMJ/ TMD): Yes No

Do you grind or clench your teeth? Yes No

Do you like your smile? Yes No

Are you satisfied with the shape and / or shade of your teeth? Yes No

Do you brush Daily? Yes No How many times a day do you brush? _____

Do you floss Daily? Yes No How many times a week do you floss? _____

Have you ever smoked? Yes No

Do you currently smoke? Yes No How Much?_____

To the best of my knowledge, the preceding answers are correct and true. I hereby give my consent for the dental staff to perform necessary dental services, with my informed consent, needed during diagnosis and treatment. If at anytime I have any questions about the treatment I am receiving, they will be promptly answered.

_____

Signature Date

WARREN S. MARSHALL, D.D.S.
3425 EXECUTIVE PARKWAY, SUITE 214
TOLEDO, OHIO 43606
wsmarshalldds@aol.com

Office 419-537-6726
Fax 419-537-6746

INSURANCE PAYMENT RESPONSIBILTY

It is your responsibility to know what benefits are covered under your insurance policy. It is your responsibility to know if a predetermination or a preauthorization of services is required by your insurance company. Though our office will assist in determining your insurance coverage prior to services, it is ultimately your responsibility to know your insurance coverage.

This signed authorization permits our office to submit claims for reimbursement to your insurance company as you have identified to us, and to directly receive payment for the services. It further permits our office to hold you financially responsible for non-covered services as permitted by your insurance company. It also enables us to hold you financially responsible for all services, if insurance coverage is not in force.

All insurance coverages to be utilized by the patient must be disclosed to our office prior to the start of any services. Insurance coverages rendered after the start of treatment, may not be honored for treatment completed or in process.

I authorize the office of Warren S. Marshall, D.D.S. to collect payment of benefits from any applicable insurance carrier for services rendered on my behalf.

I agree to be personally and fully responsible for payments under any of the following conditions:

- If I have no insurance coverage
- If I misrepresent my insurance coverage
- If I do not disclose my insurance coverages prior to services rendered
- If my insurance coverage requires I pay copays and/or deductibles
- If services are deemed to be a non-covered service by my insurance company
- If services required a predetermination or preauthorization, and I did not follow my insurance company's requirements

You may obtain patient balances, fees, deductibles and copays at any time from the office manager .

_____ _____

Signature of responsible party Date

_____ _____

Print name clearly Print patient name if different from responsible party

Warren S. Marshall, D.D.S.
3425 Executive Parkway Ste. 214
Toledo, Ohio 43606
(419) 537-6726

{NAME OF PRACTICE}

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

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 healthcare 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 our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. 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, including any revisions of our Notice, at any time by contacting:

Contact Person: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

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

SIGNATURE

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

Signature: _____ Date: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

Warren S. Marshall, D.D.S.
3425 Executive Parkway Ste. 214
Toledo, Ohio 43606
(419) 537-6726

{NAME OF PRACTICE}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____