Patient Information

Today's Date: _____

Name (PLEASE PRINT): _____

Is patient a child? YES NO

Date of Birth: _____ *SSN#:* _____

Address: _____ *Apt #:* _____

City: _____ *State:* _____ *Zip code:* _____

Home #: _____ *Work#:* _____

Cell#: _____

Email Address: _____

Driver's License #: _____ *Bank Name:* _____

Occupation & Employer: _____

Employer's Address: _____

City: _____ *State:* _____ *Zip Code:* _____

Were you referred to us? YES NO If yes, by whom? _____

Person to contact in case of emergency: _____

Home #: _____ *Work #:* _____

Cell #: _____

Person responsible for payment: _____

Home #: _____ *Work #:* _____

Cell #: _____

Insurance Information

Primary Dental Insurance: _____

Subscriber ID#: _____

Address to send claims to: _____

Phone #: _____

Subscriber Name: _____

Subscriber SSN#: _____

Subscriber Employer: _____

Subscriber DOB: _____ *Effective Date:* _____

Renewal Month: _____ *Yearly Maximum: $*_____

*Deductible Per Individual: $*_____ *Deductible Per Family: $*_____

Secondary Insurance Information (if applicable)

Secondary Dental Insurance: _____

Subscriber ID#: _____

Address to send claims to: _____

Phone #: _____

Subscriber Name: _____

Subscriber SSN#: _____

Subscriber Employer: _____

Subscriber DOB: _____ *Effective Date:* _____

Renewal Month: _____ *Yearly Maximum: $*_____

*Deductible Per Individual: $*_____ *Deductible Per Family: $*_____

Patient Signature: _____

*Date:*_____

Medical and Dental History

Today's Date: _____

Patient's name *(PLEASE PRINT):* _____ ***Date of Birth***:_____/_____/_____

Are you experiencing any dental pain or discomfort? (Please Circle)* ***NO YES*
-If yes, please indicate where your pain or discomfort is located.
(Please Circle) *UPPER LOWER RIGHT LEFT*

Are you currently under the care of a physician?* ***NO YES*
-If yes, what condition is being treated? _____

Are you allergic to any medications?* ***NO YES*
-If yes, please fill out the allergy chart provided to you in this packet.

** Are you currently taking any medications?* ***NO YES***
-If yes, please fill out the medication chart provided to you in this packet.

HAVE YOU EVER BEEN PRESCRIBED BONE DENSITY TREATMENT OR MEDICATION?* ***NO YES*

Have you had any major illnesses, operations, or hospitalizations in the last 10 years?* ***NO YES*
-If yes, Please list: _____

Have you ever had any of the following? (Please circle YES or NO for every individual question)

Aids	NO	YES	*Diabetes*	NO	YES	*Hives*	NO	YES
Alcoholism	NO	YES	*Drug Dependency*	NO	YES	*Hyper Activity*	NO	YES
Anemia	NO	YES	*Eating Disorder*	NO	YES	*Hypoglycemia*	NO	YES
Angina	NO	YES	*Emphysema*	NO	YES	*Jaundice*	NO	YES
Artificial Heart Valve	NO	YES	*Epilepsy*	NO	YES	*Kidney/Liver Disease*	NO	YES
Artificial Joints	NO	YES	*Fainting/Dizzy Spells*	NO	YES	*Mitral Valve Prolapse*	NO	YES
Arthritis/Rheumatism	NO	YES	*Fever Blisters/Cold Sores:*	NO	YES	*Night Sweats*	NO	YES
Asthma	NO	YES	*Gag Easily*	NO	YES	*Paralysis*	NO	YES
Birth Control	NO	YES	*Glaucoma*	NO	YES	*Prolonged Bleeding*	NO	YES
Blood Pressure High	NO	YES	*Headaches Frequent*	NO	YES	*Psychiatric Treatment*	NO	YES
Blood Pressure Low	NO	YES	*Heart Attack*	NO	YES	*Rheumatic Fever*	NO	YES
Blood Thinners	NO	YES	*Heart Murmur*	NO	YES	*Sickle Cell Disease*	NO	YES
Bruise Easily	NO	YES	*Hemophilia*	NO	YES	*Sinus Trouble*	NO	YES
Cancer	NO	YES	*Hepatitis*	NO	YES	*Stroke*	NO	YES
Chemotherapy/Radiation:	NO	YES	*Hereditary Disease*	NO	YES	*Tuberculosis*	NO	YES
Congenital Heart Disease:	NO	YES	*HIV Positive*	NO	YES	*Tumors*	NO	YES
Deaf:	NO	YES	*Herpes*	NO	YES	*Venereal Disease*	NO	YES

If YES to any of the above questions, please describe/explain: _____

_____

Are you allergic to or had a bad reaction to: (Please circle YES or NO for every individual question)

Aspirin:	NO	YES	*Keflex:*	NO	YES	*Penicillin*	NO	YES
Barbiturates:	NO	YES	*Latex*	NO	YES	*Sulfa:*	NO	YES
Codeine:	NO	YES	*Local Anesthetic:*	NO	YES	*Tetracycline*	NO	YES
Iodine	NO	YES	*Nitrous Oxide*	NO	YES			

Allergies & Medications

Are you allergic to any medications or products? If YES, please complete the boxes below.

ALLERGIC TO:	REACTION(S):

Please list all medications you are currently taking in the boxes provided below.

MEDICATION NAME	DOSE (mg, mcg)	HOW OFTEN (x Per day)

*Physician's name & address: _____

Phone #: _____

*Pharmacy's name & address: _____

Phone #: _____

CONSENT

I hereby authorize Doctor Schwan, after thorough explanation, to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a proper diagnosis of my dental needs. I also authorize Doctor Schwan to prescribe appropriate medication and to perform any and all forms of treatment and therapy that may be necessary (after they are discussed with me). I further authorize and consent that Doctor Schwan chooses and employs assistance as he deems fit. I understand that the use of anesthetic agents embodies a certain risk.

Signature of Patient/Parent: _____

Date: _____

Financial Arrangements & Insurance

****Please make sure you check with your insurance company to see if you are covered with us before your dental appointment.***

We are committed to providing you with the best possible care. If you have dental insurance, we will help you receive maximum allowable benefits. In order to achieve this, we need your assistance and understanding of our payment policy. We participate with Delta Dental Premier, but accept all normal insurance plans and PPO's. However, we are not contracted with any DMO's; and therefore we are out-of-network for these plans.

Returned checks and balances older than 90 days are subject to additional service fees. Charges may also be made for broken appointments and appointments canceled without 48 hours advance notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

I, the patient, understand that:

1. *My insurance is a contract between me, my employer, and the insurance company. Dr. Schwan is not a party to that contract. If an insurance company does not submit payment with 90 days, I understand that I will be responsible for any outstanding balance.*
2. *The fees charged by Steven R. Schwan, D.D.S. for services rendered to me, or to the person whom I assume financial responsibility , may exceed the fees considered "usual, customary, and reasonable", due to specialized services.*
3. *I agree to pay fees in full, even if the amount is greater than what my insurance company has paid.*
4. *Not all services are a covered benefit in all contracts; therefore, I will become responsible for payment of these services.*

We must emphasize that as dental care providers, our relationship is with you, not your insurance company*. While filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility;* ***your estimated portion is due on the date services are rendered;*** *unless prior arrangements have been made. An explanation of benefits will be sent to you once we receive payment from your insurance company. We realize that temporary financial problems may*

affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or are uncertain regarding your insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

I have read and completely understand the financial policy of Steven R. Schwan, D.D.S., and agree to abide by the policy as stated.

_____ _____

Signature of Patient or Person with authority to sign for patient *Date*

NOTICE OF PRIVACY PRACTICES

Steven R. Schwan, DDS

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.

We are required by 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.

Our practice reserves the right to change our privacy practices and the terms of this Notice at any time, provided these changes are permitted by applicable law. We will post a copy of the new terms and make it available to you upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operation.

For Example:

- ***Treatment:*** *i.e. disclosing personal health information to a physician or other healthcare provider providing treatment to you.*
- ***Payment:*** *i.e. disclosing health information to obtain reimbursement for services, confirming coverage, billing or collection activities.*
- ***Healthcare operations:*** *i.e. disclosing health information for quality assessment and improvement activities, such as evaluating practitioner and provider performance, and conduction training programs and credentialing activities.*

We may use your health information to contact you with appointment reminders, and we may leave you messages at the telephone number(s) you give us.

We may use and disclose your health information when required by law.

We may disclose your health information to a family member, friend, or other person identified by you to the extent necessary to help with your care or payment for your care, but only if you agree that we may do so. We will also use our professional judgment and our experience in allowing a person to pick-up supplies, x-rays, or other similar forms of health information on your behalf.

PATIENT RIGHTS

- ***Right to Inspect and Copy Your Health Information:*** *You have the right to get copies of your health information, with limited exceptions. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of your denial. You must make a written request to us to access you health information and this request must be signed and dated. We may charge you a fee in advance for expenses such as copies, staff time, and postage.*
- ***Request to amend your Health Information if incorrect or incomplete.***
- ***Request to specific alternative communication with you regarding your Health Information.***
- ***Request for additional restrictions on use or disclosure.***
- ***Request for an accounting of disclosures of your Health Information for purposes other than treatment, payment, and healthcare operations.***
- ***Additional written copies of the document.***

Any request to us must be made in writing, signed, dated and submitted to our office.

If you are concerned that we have violated your privacy right, you may complain to us using the following contact information. You may also submit a written complaint to the U.S. Department of Health and Human Services. 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 the U.S. Department of Health and Human Services.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Steven R. Schwan, DDS

I understand that, under the Health Insurance Portability & 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 healthcare providers who may be involved in that treatment directly and indirectly.*
- *Obtain payment from third-part payers for services provided to me.*
- *Conduct normal healthcare operations such as quality assessments and improvement activities.*

I have read and understand the Notice of Privacy Practices for Dr. Steven R. Schwan. The Notice of Privacy Practices contains a more complete description of the uses and disclosures of my health information. I understand that his practice has the right to change its Notice of Privacy Practices from time to time and that I may contact this practice at any time to obtain a current copy of their Notice of Privacy Practices.

Print Patient Name: _____ ***Date:*** _____

Signature: _____

Relationship to Patient: _____