Strawman Family Dentistry

Health History Form

Name Phone:_____
Last_____ First_____ Middle_____ Email:_____
Mailing Address: City: State: Zip:

Height:_____ Weight:_____ Sex:___ Date of Birth:_____ Social Security Number:_____
Occupation:_____ New Patients - How did you hear about us? _____
Emergency Contact:_____ Relationship:_____ Phone Number:_____

If you completed this form for someone else:
Name:_____ Relationship to Patient:_____ Phone Number: _____

Medical Information

Please mark responses with a check mark or "X" if you have or do not have the following conditions. DK = Don't Know

Cardiovascular

	Yes	No	DK
Cardiovascular Disease….....	☐	☐	☐
Atherosclerosis……..	☐	☐	☐
Angina……	☐	☐	☐
Damaged Heart Valves……..	☐	☐	☐
Congestive Heart Failure……	☐	☐	☐
High Blood Pressure……...	☐	☐	☐
Stroke…….	☐	☐	☐
Heart Attack……	☐	☐	☐
Heart Murmur…….....	☐	☐	☐
Other Congenital Heart Defects….	☐	☐	☐
Explain:_____			
Abnormal Bleeding…….	☐	☐	☐
Anemia……	☐	☐	☐
Pacemaker……	☐	☐	☐
Rheumatic Fever…….	☐	☐	☐
Mitral Valve Prolapse…….	☐	☐	☐
Hemophilia…….	☐	☐	☐
Previous Endocarditis…….	☐	☐	☐
Artificial/Prosthetic Heart Valve…	☐	☐	☐
Damaged Heart Valve……	☐	☐	☐
Congenital Heart Disease (CHD)…	☐	☐	☐
-Repaired in last 6 months	☐	☐	☐
-Unrepaired, cyanotic CHD	☐	☐	☐
-Repaired CHD with defect	☐	☐	☐

Women Only

	Yes	No	DK
Are you pregnant?.....	☐	☐	☐
Are you nursing?.....	☐	☐	☐
Are you taking birth control?.....	☐	☐	☐

Pulmonary

	Yes	No	DK
Asthma…….	☐	☐	☐
COPD……	☐	☐	☐
-Emphysema…….	☐	☐	☐
-Chronic Bronchitis…...	☐	☐	☐
Acute Bronchitis……	☐	☐	☐
Sinus Problems……..	☐	☐	☐
Tuberculosis……..	☐	☐	☐

Endocrine/Autoimmune

	Yes	No	DK
Autoimmune Disease……	☐	☐	☐
Rheumatoid Arthritis…….	☐	☐	☐
Diabetes (Type 1 or 2) ….	☐	☐	☐
Persistent Swollen Glands.	☐	☐	☐
Recurrent Infections……..	☐	☐	☐
Explain_____			
Systemic Lupus			
Erythematous……	☐	☐	☐
Thyroid Problems…….....	☐	☐	☐
Kidney Problems……..	☐	☐	☐
Liver Diseases..……	☐	☐	☐

Musculoskeletal

	Yes	No	DK
Arthritis…….	☐	☐	☐
Osteoporosis……..	☐	☐	☐
Chronic Pain……..	☐	☐	☐
Joint Replacement…….	☐	☐	☐
Explain_____			
Eye Problems……	☐	☐	☐

Neurological

	Yes	No	DK
Fainting Spells…….	☐	☐	☐
Seizure……..	☐	☐	☐
Migraines…….....	☐	☐	☐
Severe Headaches…….	☐	☐	☐
Neurological Disorders.	☐	☐	☐
Mental Health Disorders	☐	☐	☐
Explain:_____			

Gastrointestinal (GI)

	Yes	No	DK
Gastrointestinal Disease	☐	☐	☐
Acid Reflux/GERD.....	☐	☐	☐
Persistent Heartburn.....	☐	☐	☐
Ulcers.....	☐	☐	☐
Malnutrition.....	☐	☐	☐
Rapid Weight Change.....	☐	☐	☐
Eating Disorder.....	☐	☐	☐
Explain_____			

Allergies

	Yes	No	DK
Local Anesthetics.....	☐	☐	☐
Antibiotics.....	☐	☐	☐
Explain_____			
Metals.....	☐	☐	☐
Sulfa Drugs.....	☐	☐	☐
Seasonal Allergies.....	☐	☐	☐
Other_____	☐	☐	☐

Yes No DK

Have you been diagnosed with:

AIDS/HIV..... ☐ ☐ ☐

Hepatitis..... ☐ ☐ ☐

Sexually Transmitted Disease ☐ ☐ ☐ Explain: _____

Have you ever been hospitalized or had a serious illness in the past 5 years? _____

Are you currently being treated or have you been treated for cancer? _____

Are you currently being treated or have you been treated for osteoporosis? _____

Do you smoke or use tobacco products (chew, snuff, vape)? _____ Which? _____

Are you interested in quitting? _____ Do you drink alcoholic beverages? _____ How many in a week? _____

Do you use controlled substances? _____ Which? _____

Please list any prescription or over the counter medicines you are currently taking or have taken in the last six months. Please include any vitamins or herbal supplements:

_____

_____

_____

Has a physician or dentist ever recommended that you take antibiotics prior to a dental procedure? _____

Explain: _____

Please list any other conditions, problems or diseases that were not listed above that we should know about:

_____

_____

Sleep Questionnaire

Do you snore? _____ Do you feel tired, sleepy, or fatigued during the day? _____

Has anyone ever seen you stop breathing while you are sleeping? _____

I certify that I have read and understood all questions on this health history form, and that I have reported all answers truthfully, accurately and to the best of my knowledge. I acknowledge that I have had the opportunity to discuss with my dentist any questions or concerns I may have regarding the information on this health history form. I recognize that this information will be utilized by my dentist or their staff when treating me. I will not hold my dentist or their staff liable for any decision or action they make or do not make due to errors or omissions that I may have made when completing this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

Comments: _____

_____

_____

_____

_____

_____

_____

Strawman Family Dentistry

Consent for Services and Financial Policy

The following is a statement of our financial policy. All patients are required to read and sign it prior to receiving any dental treatment. If you have any questions, please ask our staff.

Overview

All patients, regardless of insurance status, are ultimately responsible for all financial balances for services, treatment or medications provided by the dentists, hygienists and staff of Strawman Family Dentistry to them or other members on their insurance plan. Financial arrangements should be made in advance of any treatment or services provided. If they are not, full payment is expected at the time of service. In addition, full payment is expected at the time of service for any emergency dental treatment.

Dental Insurance

Our office will do our best to work with you to maximize your insurance benefits. All estimated copays and deductibles are due at the time of service. We cannot guarantee an estimated copay due to the extensive number of variables of each insurance carrier and each patient's individual insurance plan. Patients are financially responsible and will be billed for any balance on their account after their insurance pays on a claim. If a patient overpays, they will be compensated for the difference at their behest.

Our office will file your insurance claims as a courtesy to you. If insurance does not pay on a claim 60 days after the initial day of treatment or service, you are responsible for payment in full at that time. In addition, it is ultimately your responsibility to know about your insurance benefits, including covered procedures and remaining allowances. Your dental insurance plan is an agreement between you and your dental benefits provider. Strawman Family Dentistry is not party to that agreement.

Missed/Broken Appointments

It can be quite difficult to fill an appointment slot that has opened last minute due to a patient failing to show up for their scheduled time or cancelling with little notice. Therefore, we request that patients let our office know at least 48 hours in advance if they need to cancel or reschedule their appointment. If they do not, they may be charged a $50 broken appointment fee.

General

A service charge of 1.5% per month on the unpaid balance of a patient's account will be charged on all accounts exceeding 60 days unless previously written financial arrangements are satisfied or have been made.

I authorize staff of Strawman Family Dentistry to use any of my personal, medical, or dental information that I have provided to the practice or that has been obtained by the practice to file and make dental insurance claims on my behalf.

I authorize staff of Strawman Family Dentistry to release any of my medical or dental information to other healthcare providers as may be deemed necessary for referral care or treatment.

I give my permission for staff of Strawman Family Dentistry to telephone or email me to discuss matters related to this form.

Print Patient Name	Date
Signature of Patient, Parent or Guardian	Relationship to Patient

Strawman Family Dentistry

Insurance Information

Primary Insurance

Insurance Plan Name and Address:_____

_____

Patient's Relationship to Insured:_____

Name of Insured: _____ Is insured a patient? _____

Insured's Birthdate:_____ Policy ID#:_____ Group #:_____

Insured's Address: _____

Street City State Zip

Insured's Employer Name:_____

Employer Address:_____

Street City State Zip

Secondary Insurance

Insurance Plan Name and Address:_____

_____

Patient's Relationship to Insured:_____

Name of Insured: _____ Is insured a patient? _____

Insured's Birthdate:_____ Policy ID#:_____ Group #:_____

Insured's Address: _____

Street City State Zip

Insured's Employer Name:_____

Employer Address:_____

Street City State Zip

Strawman Family Dentistry

Notice of Privacy Practices

This notice describes how your health information 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

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this notice about our office's privacy practices, our legal duties and your rights regarding your health information. We are required to follow the practices that are outlined in this notice while it is in effect. This notice takes effect _January 3, 2022__ 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 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. For more information about our privacy practices or additional copies of this notice, please contact us (contact information below).

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 disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other health care providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment
We may use and disclose your health information to obtain payment for services we provide to you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Health Care Operations
We may use and disclose your health information in connection with our health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of health care 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 health care 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 is 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.

Notice of Privacy Practices (continued)

To Your Family and Friends
We must disclose your health information to you, as described in the Patient Rights section of this notice. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends or any other person identified by you.

Unsecured Email
We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

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 your 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 health care. 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 may contact you about products or services related to your treatment, case management or care coordination or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without your written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of Ownership
If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

Required by Law
We may use or disclose your health information when we are required to do so by law.

Public Health
We may, and are sometimes legally obligated to, disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Notice of Privacy Practices (continued)

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 institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders
We may contact you to provide you with appointment reminders via voicemail, postcards or letters. We may also leave a message with the person answering the phone if you are not available.

Sign-In Sheet and Announcement:
Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

Patient Rights

Access
You have the right to look at or get 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 contacting our office. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter. If you request copies, there may be a charge for time spent. If you request an alternate 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 for a full explanation of our fee structure.

Disclosure Accounting
You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, health care operations and certain other activities for the last six years. 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.

Restriction
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 emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

Alternative Communication
You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Breach Notification
In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

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.

Patient Rights (continued)

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us at:

Contact: Dr. Kyle Tangney

Telephone: (513) 521-2100 Fax: (513) 521-2100

Email: office@strawmanfamilydentistry.com

Address: 800 Compton Road Unit 9 Cincinnati, OH 45231

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 send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Strawman Family Dentistry complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I,_____ [full name], have received a copy of the Strawman Family Dentistry Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

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

Personal Representative's name _____

Relationship to Patient _____

For Front Desk 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)