



BILL ANDERSON DDS, AUSTIN HOFFNER DDS, KRYSTAL DECLERCK DDS
1401 East Sandusky St. Findlay Ohio 419-424-5850

ANDERSON DENTAL CENTER WELCOMES YOU!!!

Thank you for choosing our office! We strive to deliver high quality dental care to our patients with a professional level of customer service.

Our goal is to provide the service and care that you deserve. At the onset of your treatment we will provide you with an estimate of your total treatment costs. Our goal is to help you afford your dental choices. Please understand that we can only provide you with an estimate. Should the need for additional treatment arise during the course of the original treatment plan, the fees could change. Be assured that we will notify you of fee changes and obtain your approval prior to proceeding with treatment. Please take a moment to review the financial options offered.

- **Payment in full the day of treatment.**
To demonstrate our appreciation for prompt payment, we will extend a 5% reduction of the total fee. This applies to those without insurance.
- **We are pleased to offer Third party financing for large treatment plans. Please see front desk prior to treatment for more details.**
- **As a courtesy we are happy to bill your dental plan for services. But do keep in mind that your dental benefits are a matter of contract between you and the insurance company, not Anderson Dental. Regardless of coverage your estimated portion is due in full the day of treatment. If your dental plan does not pay with-in 30 days you must pay any outstanding balance and seek reimbursement from your dental plan.**

Remember that dental insurance is not designed to cover all of your dental needs, the amount is based on the plan selected and purchased by your employer.

PAST DUE ACCOUNTS: Our experience has shown that it is important that you understand what happens if you fail to pay for our services. If your account is more than 60 days past due, (1) your relationship with The Anderson Dental Center is terminated, (2) your account will be referred to collection, (3) you agree that a collection charge of \$50.00 is added to your account, (4) your credit rating may be affected, and (5) The unpaid balance will accrue interest at the rate of 1 1/2 % per month (6) you (and the IRS) will receive an IRS Form 1099 for the income you have realized by not paying.

AS A COURTESY TO STAFF AND PATIENTS PLEASE PROVIDE 48 HOURS NOTICE IF YOU ARE UNABLE TO KEEP AN APPOINTMENT. PLEASE CALL DURING BUSINESS HOURS!

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain right 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 multiple healthcare providers who may be involved in that treatment directly and In-directly.**
- Obtain payment from third-party payers**
- Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. 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 below 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 healthcare 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.

I understand that I may revoke this consent in writing at any time, except to the extent you have taken action relying on this consent.

*******PLEASE SIGN PATIENT INFORMATION SHEET*****
THAT YOU HAVE READ AND RECEIVED A COPY
OF THE HIPAA CONSENT FORM AND
FINANCIAL OBLIGATIONS.
THANK YOU**

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____
FIRST MI LAST
ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
E-MAIL _____ CELL PHONE _____ HOME PHONE _____
SS#/SIN _____ BIRTHDATE _____
CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED
IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL _____ CITY _____ STATE/PROV. _____
PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____
BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____
WHOM MAY WE THANK FOR REFERRING YOU? _____
PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____
ADDRESS _____ HOME PHONE _____
DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____
EMPLOYER _____ WORK PHONE _____
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____
NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____
EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____
INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____
NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____
EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____
INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

I HAVE RECEIVED AND READ THE HIPAA PRIVACY ACT AND I UNDERSTAND MY FINANCIAL RESPONSIBILITIES TO THE ANDERSON DENTAL CENTER.

SIGNED/DATED _____
PATIENT/GUARDIAN

PATIENT MEDICAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO		YES	NO
1. ARE YOU IN GOOD HEALTH	<input type="checkbox"/>	<input type="checkbox"/>	10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION	<input type="checkbox"/>	<input type="checkbox"/>
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR	<input type="checkbox"/>	<input type="checkbox"/>	11. HAVE YOU HAD A RECENT WEIGHT LOSS	<input type="checkbox"/>	<input type="checkbox"/>
3. DATE OF YOUR LAST PHYSICAL EXAM: _____			12. HAVE YOU EVER TAKEN FEN-PHEN/REDUX	<input type="checkbox"/>	<input type="checkbox"/>
4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____			13. DO YOU USE TOBACCO	<input type="checkbox"/>	<input type="checkbox"/>
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN	<input type="checkbox"/>	<input type="checkbox"/>	14. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES	<input type="checkbox"/>	<input type="checkbox"/>
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS PLEASE EXPLAIN. _____	<input type="checkbox"/>	<input type="checkbox"/>	15. ARE YOU WEARING CONTACT LENSES	<input type="checkbox"/>	<input type="checkbox"/>
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____	<input type="checkbox"/>	<input type="checkbox"/>	16. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)	<input type="checkbox"/>	<input type="checkbox"/>
8. HAVE YOU HAD ANY ABNORMAL BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	17. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT	<input type="checkbox"/>	<input type="checkbox"/>
9. DO YOU BRUISE EASILY	<input type="checkbox"/>	<input type="checkbox"/>	WOMEN ONLY: ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT		
			ARE YOU NURSING		
			ARE YOU TAKING BIRTH CONTROL PILLS		

	YES	NO		YES	NO
ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:			HIVES OR SKIN RASH	<input type="checkbox"/>	<input type="checkbox"/>
LOCAL ANESTHETICS LIKE NOVOCAINE	<input type="checkbox"/>	<input type="checkbox"/>	FAINING OR DIZZY SPELLS	<input type="checkbox"/>	<input type="checkbox"/>
PENICILLIN OR OTHER ANTIBIOTICS	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
SULFA DRUGS	<input type="checkbox"/>	<input type="checkbox"/>	AIDS OR HIV INFECTION	<input type="checkbox"/>	<input type="checkbox"/>
BARBITURATES, SEDATIVES OR SLEEPING PILLS ..	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
ASPIRIN	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>
IODINE	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS OR RHEUMATISM	<input type="checkbox"/>	<input type="checkbox"/>
ANY METALS (E.G., NICKEL, MERCURY, ETC.)	<input type="checkbox"/>	<input type="checkbox"/>	JOINT REPLACEMENT OR IMPLANT	<input type="checkbox"/>	<input type="checkbox"/>
LATEX / RUBBER	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER	<input type="checkbox"/>	<input type="checkbox"/>
OTHER (PLEASE LIST) _____			KIDNEY TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:			TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	PERSISTENT COUGH	<input type="checkbox"/>	<input type="checkbox"/>
SCARLET FEVER	<input type="checkbox"/>	<input type="checkbox"/>	COUGH THAT PRODUCES BLOOD	<input type="checkbox"/>	<input type="checkbox"/>
HEART DEFECT OR HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY (CANCER, LEUKEMIA)	<input type="checkbox"/>	<input type="checkbox"/>
HEART TROUBLE, HEART ATTACK, OR ANGINA ...	<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>
SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>
PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>
HEART SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUSNESS	<input type="checkbox"/>	<input type="checkbox"/>
HIGH/LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	TONSILLITIS	<input type="checkbox"/>	<input type="checkbox"/>
CONGENITAL HEART PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	TUMORS	<input type="checkbox"/>	<input type="checkbox"/>
SWELLING OF FEET, ANKLES, HANDS	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL HEALTH CARE	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS, JAUNDICE OR LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	BACK PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	CHEMICAL DEPENDENCY	<input type="checkbox"/>	<input type="checkbox"/>
SINUS TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE	<input type="checkbox"/>	<input type="checkbox"/>
LUNG OR BREATHING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	CORTISONE TREATMENT	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA OR HAY FEVER	<input type="checkbox"/>	<input type="checkbox"/>	COLD SORES/FEVER BLISTERS	<input type="checkbox"/>	<input type="checkbox"/>
			HYPOGLYCEMIA	<input type="checkbox"/>	<input type="checkbox"/>
			EATING DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>

ITEM 07-0515775/27011

PATIENT NUMBER _____

PATIENT DENTAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED _____

	YES	NO		YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING.	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY.	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS.	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH.	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS.	<input type="checkbox"/>	<input type="checkbox"/>	DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH.	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU FEEL PAIN TO ANY OF YOUR TEETH.	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS).	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH.	<input type="checkbox"/>	<input type="checkbox"/>	EVER WORN A BITE PLATE OR OTHER APPLIANCE.	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES.	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST.	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?			HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS.	<input type="checkbox"/>	<input type="checkbox"/>
CLICKING.	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU WEAR DENTURES OR PARTIALS.	<input type="checkbox"/>	<input type="checkbox"/>
PAIN (JOINT, EAR, SIDE OF FACE).	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, DATE OF PLACEMENT _____		
DIFFICULTY IN OPENING OR CLOSING.	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS.	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE FREQUENT HEADACHES.	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU CLENCH OR GRIND YOUR TEETH.	<input type="checkbox"/>	<input type="checkbox"/>			

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X _____ DATE _____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

DOCTOR'S COMMENTS _____

_____ SIGNATURE _____ DATE _____

PATIENT NUMBER _____