# PATIENT INFORMATION

MINTER DENTISTRY
FAMILY AND SEDATION CARE

LAST NAME | FIRST NAME | MI

ADDRESS | CITY/STATE | ZIP

SEX: M | F MARITAL STATUS: _____ BIRTH DATE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL: _____

EMAIL ADDRESS: _____ SOCIAL SECURITY NUMBER: _____

DRIVERS LICENSE NUMBER: _____

HOW DID YOU HEAR ABOUT US? _____

EMPLOYER'S NAME: _____ EMPLOYER'S ADDRESS: _____

SPOUSE'S NAME: _____ SPOUSE'S EMPLOYER: _____

SPOUSE'S WORK PHONE: _____ SPOUSE'S CELL: _____

EMERGENCY CONTACT: _____

PHONE NUMBER: _____

# PATIENT INFORMATION

MINTER DENTISTRY
FAMILY AND SEDATION CARE

## PRIMARY DENTAL INSURANCE

SUBSCRIBER NAME: _____ SSN: _____ BIRTH DATE: _____

INSURANCE CARRIER: _____ GROUP NUMBER: _____

MAILING ADDRESS: _____ PHONE #: _____ ID #: _____

EMPLOYER NAME: _____ EMPLOYER PHONE #: _____

## SECONDARY DENTAL INSURANCE

SUBSCRIBER NAME: _____ SSN: _____ BIRTH DATE: _____

INSURANCE CARRIER: _____ GROUP NUMBER: _____

MAILING ADDRESS: _____ PHONE #: _____ ID #: _____

EMPLOYER NAME: _____ EMPLOYER PHONE #: _____

## RESPONSIBLE PARTY:

PERSON RESPONSIBLE FOR ACCOUNT (IF NOT SELF): _____

RELATIONSHIP: _____ ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____ CELL: _____

# HEALTH INFORMATION

MINTER DENTISTRY
FAMILY AND SEDATION CARE

## Please check any of the following conditions that apply:

- ☐ AIDS/HIV Positive
- ☐ Hepatitis A, B or C
- ☐ Arthritis/Gout
- ☐ Shingles
- ☐ Breathing Problems/Asthma
- ☐ Bruise Easily
- ☐ Hay Fever/Allergies
- ☐ Pain in Jaw Joints
- ☐ Lupus
- ☐ Chest Pain
- ☐ Thyroid Problem
- ☐ Diabetes
- ☐ Easily Winded
- ☐ Sleep Apnea
- ☐ Smoker/Chewing Tobacco
- ☐ Rheumatic Fever
- ☐ Low/ High Cholesterol
- ☐ Blood Disorder
- ☐ Liver Disease
- ☐ Glaucoma
- ☐ Osteoporosis
- ☐ Depression
- ☐ Emphysema/COPD
- ☐ Drug Addiction
- ☐ Low/ High Blood Pressure
- ☐ Artificial Heart Valve
- ☐ Irregular Heartbeat
- ☐ Epilepsy or Seizures
- ☐ Frequent Headaches
- ☐ Cancer
- ☐ Heart Attack/Heart Troubles
- ☐ Pacemaker
- ☐ Chemotherapy
- ☐ Tuberculosis
- ☐ ADD/ADHD
- ☐ Mental Health Conditions
- ☐ Fibromyalgia/Chronic Fatigue Syndrome
- ☐ Artificial Joint
- ☐ Kidney Problems
- ☐ Stomach/Intestinal Disease
- ☐ Stroke

Do you have any conditions or illnesses not stated above? If so, please list them below.

_____

How much do you smoke per day? _____

Do you use recreational drugs? _____

Please list all prescriptions and any over-the-counter medications you are currently taking.

_____

_____



2694 Easton St NE | Canton, OH 44721
**330.662.5454**
minterdentistry.com

# HEALTH INFORMATION

MINTER DENTISTRY
FAMILY AND SEDATION CARE

Check any of the following you may be allergic to:

- ☐ ASPIRIN
- ☐ CODEINE
- ☐ LATEX
- ☐ ANY METALS
- ☐ LOCAL ANESTHETICS
- ☐ ERYTHROMYCIN
- ☐ PENICILLIN
- ☐ SULFA
- ☐ ACRYLIC
- ☐ ANY NARCOTICS

☐ OTHER? _____

FOR WOMEN ONLY:

1. Are you pregnant or think you may be pregnant? YES | NO

2. Are you nursing? YES | NO

3. Are you taking Oral Contraceptives? YES | NO

I certify that I have read and understand the above information to the best of my knowledge. The about 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 the third-party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist 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.

Consent signed by:

_____

Print Name

_____

Signature Date



2694 Easton St NE | Canton, OH 44721
**330.662.5454**
minterdentistry.com

# HIPAA COMPLIANCE PATIENT CONSENT FORM

MINTER DENTISTRY
FAMILY AND SEDATION CARE

This notice of Privacy Practices provides information about how we may use or disclose protected health information. Included is a patient's rights section describing your rights under the law. You confirm with your signature that you have reviewed our notice before signing this consent form.

If the terms of this notice change, you will be notified at your next visit to update your consent with a signature and date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Do we have your consent to:

- Call, email, or send a text to confirm appointments? YES | NO
- Leave a message on your answering machine at home or on your cell phone? YES | NO
- Discuss your medical condition with members of your family? YES | NO

If YES, please list the family members below:

_____

_____

Consent signed by:

_____

Print Name

_____

Signature Date

MINTER DENTISTRY
FAMILY AND SEDATION CARE

2694 Easton St NE | Canton, OH 44721
**330.662.5454**
minterdentistry.com

MINTER DENTISTRY
FAMILY AND SEDATION CARE

**Dr. Nathan Minter**
2694 Easton St NE
Canton, OH 44721
330-662-5454
office@minterdentistry.com

We are committed to providing the best possible care to our patients and their families, and feel this goal is best achieved if everyone is aware of our office policies. Your clear understanding of our financial policy is important to our professional relationship.

The benefit packages provided by insurance companies vary from employer to employer. Dental insurance is a contract between you, your employer, and your insurance company. Not all services are a covered benefit in all contracts. We are happy to bill your insurance company, but if we are not paid in a timely fashion, you will be expected to pay the bill in full. Any services rendered to you or your covered family that are not a covered benefit according to your insurance will be billed to you.

IF YOU DO NOT CARRY DENTAL INSURANCE, YOUR BALANCE IS DUE AT THE TIME SERVICE IS RENDERED.

All patients are encouraged to review the cost of their treatment by asking for a treatment plan estimate if one is not provided to them. If you have insurance, we can submit a pre-determination to your insurance company for any treatment recommended to you. Please take note that this process is sometimes lengthy, delaying treatment. All patients are encouraged to discuss payment options with our front desk staff. Our office accepts cash, personal checks, Visa, Master Card, Discover, American Express, and Care Credit. Care Credit can give you extended time to pay off your dental treatment. We also offer an in-office insurance plan for those without dental insurance.

Broken appointments are a cost to us, to you, and to other patients who could have used the time set aside for your appointment. Please call us at least 24 hours in advance to make any scheduling changes you need. We reserve the right to charge a fee to your account if we find that you continue to miss appointments without advance notice.

Any charges remaining unpaid sixty days after the date of service or sixty days after insurance payment are considered past due. In this case, we will make every effort to contact the person responsible for the delinquent balance. However, if no effort is made to pay the balance due, it may be sent to a collection agency. In this case, the responsible person may be asked to seek dental care for themselves and their families elsewhere.

I have read and understand the financial policy.

I agree to keep Minter Dentistry accurately informed of my insurance status for either myself and/or family members and to assign benefits to Nathan Minter, D.M.D.

_____

Printed Name and Signature of patient or responsible party Date