PATIENT INFORMATION (Confidential and Necessary) Today's Date ____-____-____

Name__________________________ Birth Date: ___-___-___ Age:__________

Home Address__________________City ____________State______ZIP________

Phone Numbers: Home____-____-_____Work____-____-_____Cell _____-_____-______

e-Mail Address_____________@__________Social Security Number _____-____-_____

Your Employer ______________________Position__________How Long?________

Employer's Address____________________City __________State_____ZIP______

Spouse/Parent/Guardian (circle one)__________________Other Guardian________

Their Employer___________________Position______________How Long?________

Nearest Relative Not Living With You____________________Relationship?________

Their Phone Number_____-_____-______City ____________________State______

Whom Should We Contact In An Emergency?_______________Phone____-____-_____

Physician ____________________________Phone Number_____-_____-______

Person Responsible For This Account ________________________(signature)

DENTAL INSURANCE INFORMATION (to process your claim)

Primary Dental Ins. Co. _________________Employer______________Group#______

Phone____-____-_____Annual Benefit Maximum______________Annual Deductible_______

Employee's Name____________________SS#_____-____-_____Birthdate____-____-____

*Secondary Insurance Co.*________________Employer______________Group#______

Phone____-____-_____Annual Benefit Maximum______________Annual Deductible_______

Employee's Name____________________SS#____-____-____Birthdate____-____-____

Whom May We Thank For This Referral (How did you find out about us)?______________

Are You Having Any Dental Problems? Yes No (please circle) Please Describe:____________

____

Do You Having Any Hobbies or Special Interests?____________________________

____

(Over)

PERSONAL NOTES AND INFORMATION

Other Family Members:

Is there anything that you would like us to know about you, your dental history, or any other concerns?

Do you have a fear of dental treatment that has prevented you from seeking the care that you need or want?
Yes No_______________

Would you be interested in sedation, either Nitrous Oxide (laughing gas) or taking a medication to make your treatment proceed easier?
Yes No

Notes:

Informed Consent
General Consent for Treatment

I understand that I have the following conditions requiring dental treatment in the opinion of my dentist:

All dental and anesthetic procedures have associated risks. These may be, but are not limited to:

- Drug reactions and side affects
- Damage to adjacent teeth or fillings
- Post-operative infection
- Post-operative bleeding that might require additional treatment
- Delayed healing of an extraction site, (dry socket) necessitating additional care
- Sinus involvement during removal of upper molars which may require additional treatment of surgical repair at a later date
- Involvement of the nerves during removal of teeth resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas
- Bruising, swelling, sensitivity, or pain
- Failure of the dental procedure necessitating additional treatment
- Breakage of dental instruments inside tooth canals making additional treatment necessary
- Complications during treatment necessitating referral to a specialist

I understand the recommended treatment for my conditions, the risks of such treatment, any alternatives and risks, as well as the consequences of doing nothing. Any fee(s) involved have also been explained. All of my questions have been answered, and I have not been offered any guarantees.

Patient Signature_______________ Date_______________

Witness_______________ Date_______________

Craig C. Callen D.D.S. & Associates

PATIENT MEDICAL HISTORY

Date: / / Blood Pressure: /
(taken by our office)

MEDICAL ALERTS!

Patient Name: Age: Weight: Height:

1.) Have you been hospitalized in the last 5 years? Why?	YES NO
2.) Are you taking any medications? What?	YES NO
3.) Are you allergic to any medications? What?	YES NO
4.) Do you use alcohol? How much a week?	YES NO
5.) Do you use tobacco products? How much a day?	YES NO
6.) Have you had any allergies or problems with Novocaine?	YES NO
7.) Have you had any allergies to latex?	YES NO
8.) Do you have any problem bleeding a long time if you cut yourself?	YES NO
9.) WOMEN: Are you pregnant, or think you may be? What month?	YES NO
Are you taking birth control pills?	YES NO

10.) IF YOU HAVE HAD ANY OF THE FOLLOWING PROBLEMS, PLEASE CIRCLE THE CORRECT RESPONSE. IF SOMEONE IN YOUR FAMILY HAS HAD THE PROBLEM, PLEASE WRITE AN "F" FOR FAMILY NEXT TO THE CORRECT RESPONSE. THANK YOU.

Heart Disease or Attack	Jaundice or Liver Disease	Diabetes
Angina (Chest Pain)	Hepatitis A	Tuberculosis
Heart Murmur	Hepatitis B	Arthritis
Mitral Valve Prolapse	Hepatitis Non A, B	Rheumatism
Artificial Valve	A.I.D.S. or H.I.V.	Artificial Joints (or pins)
Pacemaker	Blood Transfusion	Cancer
High Blood Pressure	Hemophilia	Radiation Therapy
Low Blood Pressure	Venereal Disease	Chemotherapy
Swollen Ankles	Sinus Problems	Drug or Alcohol Problems
Anemia	Asthma	Psychiatric Treatment
Thyroid Disease	Hay Fever/ Allergies	Fainting or Dizziness
Glaucoma	Ulcers	Epilepsy

NOTES:

11.) Do you get shortness of breath, or chest pain walking up stairs?	YES NO
12.) Do you need to prop yourself up with pillows to sleep?	YES NO
13.) Do you have any health problems not listed? What?	YES NO

To the best of my knowledge, all of the preceding answers are true and correct. I will inform the doctor if there are any changes in my health, or medicines at my next appointment. I am also now aware that the doctor may take pictures for diagnosis and documentation purposes and that I give my permission for these pictures to be used for educational and scientific purposes. I authorize the insurance company to pay the dentist benefits payable to me for services rendered and authorize the use of this signature for insurance submission. I authorize release of information to the insurance company. I understand that I am financially responsible for my treatment regardless of what my insurance may or may not pay.

Patient(Parent) Signature: Dr.

Craig C. Callen D.D.S. & Associates

MEDICAL HISTORY UPDATE **PATIENT:**

Date: / /	Change in Health:
Change in Medications:	
Patient Signature:	Dr.

Date: / /	Change in Health:
Change in Medications:	
Patient Signature:	Dr.

Date: / /	Change in Health:
Change in Medications:	
Patient Signature:	Dr.

Date: / /	Change in Health:
Change in Medications:	
Patient Signature:	Dr.

Date: / /	Change in Health:
Change in Medications:	
Patient Signature:	Dr.

Date: / /	Change in Health:
Change in Medications:	
Patient Signature:	Dr.

DENTAL HISTORY: Craig C. Callen D.D.S. & Associates

Patient name: | I.D. # | Date / /

1. What is your primary concern?

2. Is there anything you dislike about the looks of your teeth?

3. When was your last dental exam? Cleaning?
4. Have you been under regular care? Yes No
5. Why did you decide to change dentists?

6. Have you had any: Root canal? Yes No Gum treatment? Yes No
   Braces? Yes No Extractions? Yes No When?
   Why? Notes:

7. Do you have any replacements? Yes No When?

8. Do you snack between meals? Yes No Notes:

   Pop, Kool-aid, Coffee/Tea? How much?
9. How do you take care of your teeth on a daily basis?

   a.) Brushing: hard medium soft

   b.) Flossing: Yes No How often?
   c.) Mouthwash: Yes No Brand?
   d.) 0ther:
   e.) Has a dentist or hygienist shown you how to brush and floss?
   Yes No
10. Do you ever notice your gums bleeding or tender when you brush or floss? Yes No Where?
    How long?

11. Do you have any problem with bad breath? Yes No Notes:

12. Do you have any problem with food packing between your teeth?
    Yes No Where?
13. Are you aware of any loose teeth? Yes No Where?
    How long?
14. Do you ever clench or grind your teeth? Yes No When?

15. Do you ever notice your jaw popping or clicking? Yes No
    How long? Any pain or limited opening?

16. Do you have any problems with frequent headaches? Yes No
    When?
    Where?
    How many a week?
17. Have you ever worn a bite plane, night guard, or had your bite adjusted? Yes No When?
18. Are there any other problems you feel we should be aware of?

19. PEDO: A.) Any injuries to face or teeth?
    B.) Are you or have you taken a fluoride vitamin or rinse?

    C.) Any habits?

TREATMENT EXPLANATION PATIENT: DATE: / /

TOOTH		EXISTING					SEALANT
	1						
	2						
	3						
A	4						
B	5						
C	6						
D	7						
E	8						
F	9						
G	10						
H	11						
I	12						
J	13						
	14						
	15						
	16						
	17						
	18						
	19						
K	20						
L	21						
M	22						
N	23						
O	24						
P	25						
Q	26						
R	27						
S	28						
T	29						
	30						
	31						
	32						
TOTALS							

SPECIALIST REFERRAL:____

Craig C. Callen, D.D.S. & Associates L.L.C.

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy as a patient. Implementation of HIPAA requirements offcially began on April 14, 2003, While we have followed these policies for years, there have been a few updates that we wanted you to be aware of. This is a shortened version of the HIPAA policy. The full policy is available for your review if you would like.

There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal exchange of information within our office. HIPAA provides certain rights and protections to you as the patient. We follow these guidelines and provide you with the quality care you deserve. Additional information is avaliable from the U.S. Department of Health and Human Services. You can find them online at www.hhs.gov

This summarizes our policy here at Craig C. Callen, D.D.S. & Associates.

Patient information will be kept confidential except when it is necessary to provide services or to ensure that all administrative matters related to your care are handled properly. This may include, but not limited to, the sharing of information with other healthcare providers, laboratories, and health insurance companies. Patient information (treatment plans, insurance forms, eob's etc.) may be stored in file cabinets not accessible by patients. Preparing for and during your dental visit such records may be left, at least temporarily, in administrative areas such as the front office, doctors desk, examination room,etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

We send out reminders to our patients. We do this by one or more of the following; e-mail, texting, calling, and sending postcards. We try to make every effort to remind you of your appointment and any treatlment that you need. We may send you other communications informing you of changes to office pollcy and new technology that you might find valuable or informative. We also may send out newsletters or special promotions that we are offfering.

You agree to us sending electronic e-referrals to specialists, which include your PHI and x-rays, if needed. We also send electronic claims to your dental insurance, which includes submitting PHI to receive payment for services provided.

You give us permission to remind you to take pre-medication prior to appointmants, if applicable.

You give us permission to call in any prescriptions you may need and share your PHI with the pharmacist.

The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

You understand and agree to inspections of the office and review of documents which may include PHI by government agencles or insurance payers in normal performance of their duties.

You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor, and understand that you have the right to file a complaint. We can help you do this, and you will not be penalized for filing a complaint.

Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services without your permission.

We agree to provide patients with access to their records in accordance with state and federal laws. We may update this policy as needed to better serve the needs of our patients and our practice.

By signing below, I agree that, I have been offered the HIPAA policy, and understand and acknowledge my agreement to the terms set forth in the HIPAA information and consent form and any future update to this policy.

Patient: ____

Signature: ____

Date: ________________

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize Craig C. Callen & Assoc. L.L.C. to disclose your PHI to the following individuals (check all that apply).

Name: ______________________ **Relationship to Patient:** ______________
Telephone: (______)____________ **Email:** ______________________
Types of Information: ☐ Appointment Reminders ☐ Results (X-Ray, etc) ☐ Financial ☐ Other: ________
Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: ________

Name: ______________________ **Relationship to Patient:** ______________
Telephone: (______)____________ **Email:** ______________________
Types of Information: ☐ Appointment Reminders ☐ Results (X-Ray, etc) ☐ Financial ☐ Other: ________
Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: ________

Name: ______________________ **Relationship to Patient:** ______________
Telephone: (______)____________ **Email:** ______________________
Types of Information: ☐ Appointment Reminders ☐ Results (X-Ray, etc) ☐ Financial ☐ Other: ________
Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: ________

☐ **None of the above** **Signature:** ______________________

Dr. Craig Callen & Associates

552 South Trimble Road

Mansfield, Ohio 44906

DELINQUENT ACCOUNT:

Any delinquent account may be placed with a collection agency if we are unable to work out a financial solution. Accounts placed with a collection agency will be assessed an additional charge up to 1.5% per month. If your account is placed with a collection agency and legal action is initiated, you will be responsible for any amount due, including but not limited to interest, fees, and/or expenses incidental to the principal obligation prior to a judgment being rendered against you.

BROKEN APPOINTMENTS:

When you miss an appointment or change on short notice, it affects many people. The time is reserved just for you. Missed appointments delay your treatment, but it also takes time away from other patients and leads to higher overhead and increased fees. **We request a two day notice of any change**.

Our policy is:

1st broken appointment/short notice change - We will waive our usual $100 missed appointment/late cancellation fee. **We request a two day notice of any change**.

2nd broken appointment/short notice change - A $100 charge will be reflected on your statement and a $100 deposit for reserving your next appointment time.

3rd broken appointment/short notice change - A $100 charge on your statement plus a $100 deposit for reserving your next appointment time. If you are unable to keep this appointment and do not give us at least 2 business days notice you will forfeit this deposit.

Of course, we understand there are legitimate reasons patients have to occasionally miss appointments. Every situation will be weighed on its own merits.

Thank you for understanding our policy and for your consideration.

I/We the undersigned acknowledge and agree to the terms and conditions of Craig C. Callen, D.D.S. & Associates including but not limited to the fees and conditions contained herein.

Patient Signature________________________ Date______________________________

Updated 3/2022