# Skiffey Family Dentistry

Welcome to our Practice! Please provide us with the following information

## Confidential Information Questionnaire

| Patient's Legal Name Last, First MI | Date of Birth | Sex | Social Security # |
|---|---|---|---|
| | | | |

| Preferred Name | Home Phone # | Cell Phone # | Work Phone # |
|---|---|---|---|
| | | | |

| Patient's Address Street Apt # City State Zip | Email |
|---|---|
| | |

| Marital Status S☐ M☐ D☐ W☐ | Patient's Employer/Address | Driver's License |
|---|---|---|
| | | |

Who can we thank for referring you to our office?

I prefer to be contacted via:

☐ Cell Phone ☐ Work Phone ☐ Email ☐ Home Phone

## Emergency Contact/Legal Guardian Information

| Name | Relationship |
|---|---|
| | |

| Home Phone # | Work Phone # | Cell Phone # |
|---|---|---|
| | | |

## Insurance Contact Information

| Insurance Company | Insurance Address | Insurance Phone # |
|---|---|---|
| | | |

| Subscriber's Name | Patient's Relationship to Subscriber | Subscriber's DOB | Subscribers SSN |
|---|---|---|---|
| | | | |

| Group #/Member ID | Employer of Insured | Employer's Address |
|---|---|---|
| | | |

## Assignment & Release

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he/she so determines. In consideration of the services rendered to me by this dental office, I am obligated to pay the office in accordance with its credit terms and policy.

I consent to making photographs & x-rays before, during and after treatment.

Signature of Patient/Legal Guardian _____ Date _____

Patient Name: DOB:

| Dental History |
|---|
| Approximate date of last dental cleaning, exam and x-rays?<br><br>Why did you leave your last dentist? |

| Personal Dental History | Yes | No |
|---|---|---|
| Are you currently in any discomfort? | | |
| Have you ever had complications following dental treatment? | | |
| Have you had any teeth removed/are you missing any teeth? | | |
| Have you ever had trouble getting numb or had a reaction to anesthetic? | | |
| Are you fearful of dental treatment? | | |
| Would you be interested in Nitrous Oxide (laughing gas) to alleviate dental anxiety? (not covered by insurance) | | |

| Oral Hygiene Habits | Answer |
|---|---|
| How many times do you brush your teeth per day? | |
| Which tooth brush do you use, Manual or Electric? | |
| How many times do you floss per week? | |
| Do you use a Waterpik? | |
| Do your gums bleed when you brush or floss? | |

| Smile Characteristics | Yes | No |
|---|---|---|
| Is there anything about the appearance of your teeth that you would like to change? | | |
| Have you ever whitened your teeth? | | |
| Would you like to whiten your teeth? | | |
| Did you ever have braces? (orthodontic treatment) | | |

| Dental Health | Yes | No |
|---|---|---|
| Have you ever been diagnosed with gum disease? | | |
| Have you experienced gum recession? | | |
| Do you feel like your mouth is often dry? | | |
| Are you sensitive to hot, cold, biting pressure, eating sweets? Circle one | | |
| Do you chew ice, bite your nails, use your teeth to hold objects? | | |
| Do you clench your teeth in the daytime or grind your teeth at night? | | |
| Do you wake up with tension headaches or sore teeth? | | |
| Do you wear or have you ever worn a bite appliance? (grinding appliance) | | |

Signature of patient or legal guardian Date

_____ _____

Dr. Robert Skiffey DDS Inc

# Eaglesoft Medical History

Patient Name: Birth Date:

| | | |
|---|---|---|
| Have you had a physical exam or wellness exam in the last year? | ◯Yes ◯No | If yes |
| Are you currently being treated for any specific medical conditions? | ◯Yes ◯No | If yes |
| Have you EVER been hospitalized or had a surgery/operation? | ◯Yes ◯No | If yes |
| Have you ever had a serious head or neck injury? | ◯Yes ◯No | If yes |
| Are you currently undergoing chemotherapy, radiation or dialysis? | ◯Yes ◯No | If yes |
| Are you taking any medications, pills, or drugs? (Include Vitamins/Supplements) | ◯Yes ◯No | If yes |
| Are you taking any blood thinners or platelet inhibitors? (Examples: Coumadin/Warfarin/Plavix/Xarelto) | ◯Yes ◯No | If yes |
| Have you ever taken Fosamax, Boniva, Actonel or any other bisphosphonates for Osteoporosis? | ◯Yes ◯No | If yes |
| Do you have ANYTHING artificial in your body? (examples: pins, plates, screws, implants) | ◯Yes ◯No | If yes |
| Have you ever been asked to take an antibiotic before dental treatment due to a specific medical condition or surgery? | ◯Yes ◯No | If yes |
| Do you use any tobacco products or any type of electronic nicotine delivery device? | ◯Yes ◯No | If yes |
| Do you use any controlled substances? (Certain controlled substanced may interact with local anesthetics!) | ◯Yes ◯No | If yes |

Women:

☐ Are you pregnant?

Are you allergic to any of the following?

| | | | |
|---|---|---|---|
| ☐ Acrylic | ☐ Codeine | ☐ Latex | ☐ Nitrile |
| ☐ Amoxicillin/Penicillin | ☐ Ibuprofen | ☐ Local Anesthetics | ☐ Other Antibiotics (list below) |
| ☐ Aspirin | ☐ Iodine | ☐ Metal | ☐ Sulfa Drugs |

Are you allergic to anything not listed above? ☐ If yes

Do you have, or have you had, any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV | ◯Yes ◯No | Cancer | ◯Yes ◯No | Hay Fever/Allergies | ◯Yes ◯No | Lung Disease/Disorder | ◯Yes ◯No |
| Acid Reflux | ◯Yes ◯No | Chemotherapy | ◯Yes ◯No | Headaches or Migraines | ◯Yes ◯No | Mitral Valve Prolapse | ◯Yes ◯No |
| Alzheimer's disease | ◯Yes ◯No | Cold Sores/Fever Blisters | ◯Yes ◯No | Heart Attack/Failure | ◯Yes ◯No | Osteoporosis/Osteopenia | ◯Yes ◯No |
| Anaphylaxis | ◯Yes ◯No | Congenital Heart Disorder | ◯Yes ◯No | Heart Murmur | ◯Yes ◯No | Pancreatitis | ◯Yes ◯No |
| Anemia | ◯Yes ◯No | Congestive Heart Failure | ◯Yes ◯No | Heart Pacemaker | ◯Yes ◯No | Psychiatric Care | ◯Yes ◯No |
| Angina or Chest Pains | ◯Yes ◯No | Dementia | ◯Yes ◯No | Heart Trouble/Disease | ◯Yes ◯No | Radiation Treatments | ◯Yes ◯No |
| Arthritis/Gout/Rheumatism | ◯Yes ◯No | Diabetes | ◯Yes ◯No | Hepatitis A, B or C | ◯Yes ◯No | Shingles | ◯Yes ◯No |
| Artificial Heart Valve | ◯Yes ◯No | Dialysis | ◯Yes ◯No | Herpes | ◯Yes ◯No | Stent or Shunt Placement | ◯Yes ◯No |
| Artificial Joint | ◯Yes ◯No | Drug Addiction | ◯Yes ◯No | High Blood Pressure | ◯Yes ◯No | Stomach/Intestinal Disease | ◯Yes ◯No |
| Atrial Fibrilation (AFIB) | ◯Yes ◯No | Dry Mouth, Excessive Thirst | ◯Yes ◯No | High Cholesterol | ◯Yes ◯No | Stroke | ◯Yes ◯No |
| Asthma/Breathing Problems | ◯Yes ◯No | Epilepsy or Seizures | ◯Yes ◯No | Hypoglycemia | ◯Yes ◯No | Thyroid Disease | ◯Yes ◯No |
| Blood Disease/Disorder | ◯Yes ◯No | Excessive Bleeding | ◯Yes ◯No | Hypotension | ◯Yes ◯No | Tuberculosis | ◯Yes ◯No |
| Blood Transfusion | ◯Yes ◯No | Fainting Spells | ◯Yes ◯No | Kidney Disease/Disorder | ◯Yes ◯No | Ulcers | ◯Yes ◯No |
| Bruise Easily | ◯Yes ◯No | Frequent Cough | ◯Yes ◯No | Liver Disease/Disorder | ◯Yes ◯No | Unexplained Weight Loss | ◯Yes ◯No |

Have you ever had any serious illness not listed above? ◯Yes ◯No If yes

Additional information or comments regarding conditions listed above:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

Skiffey Family Dentistry
Robert J. Skiffey DDS. INC.

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

## OUR LEGAL DUTY

We are required by applicable Federal and State law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, your 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. This Notice takes effect April 14, 2003, 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 the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we requested or reviewed 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.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed on the first page of this Notice.

## USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose your health information about you for treatment, payment and healthcare operations. For example:

**Treatment**: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment**: We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations**: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare 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 healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purposes. If you give us authorization you may revoke it in writing at anytime. Your revocation will not affect any use or disclosures permitted by your authorization white it was 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.

**To Your Family and Friends**: We must disclose your health information to you, as described in the Patient Rights section of the Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**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, location, general condition, or death. If you are present prior to use or disclosure of our incapacity or emergency circumstances we will disclose health information base on determination using our professional judgment and our experience with common practice to make reasonable inferences of our 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 will not use or disclose health information for marketing communications without your written authorization.

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

**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 patient under certain circumstances.
**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, such as voicemail messages, postcards, or letters. This will require a written authorization.

**PATIENT RIGHTS**
**Access:** You have the right to review and receive 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 that you request unless we cannot practically 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 using the contact information listed on the first page of the Notice. 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 to the address on the first page of this Notice. If you request copies we will charge you $1.00 for each page $10 per hour of staff time to locate and copy your health information and postage if you want the copies mailed to you. If you request an alternative specified 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 using the information listed on the first page of this Notice for a full explanation of our fee structure).
**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 12, 2003. 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).
**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means, or at alternative locations. You must make your request in writing, and it must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location requested.
**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.
**Electronic Notice:** If you receive this Notice on our Website or by electronic mail (email), you are entitled to receive this Notice in written form

**QUESTIONS AND COMPLAINTS**
If you want more information about our privacy practices or you have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights; you disagree with a decision we made concerning access to your health information; our response to a request you made to amend or restrict the use or disclosure of your health information, or a request for us to communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

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.

**Contact Officers: Hally Pfister or Sarah Carpenter**
**Telephone: 330-336-6611**
**Fax: 330-336-6612**
**Email: SkiffeyDDS@gmail.com**
**Address: 300 Weatherstone Dr Ste 111, Wadsworth, Ohio 44281**

# Skiffey Family Dentistry
# Acknowledgement of Receipt of Notice of Privacy Practices

*You May Refuse to Sign This Acknowledgment*

I attest that I have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

_____

**For Office 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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

_____

_____

_____

# Skiffey Family Dentistry
# Consent for Use and Disclosure of Health Information

Name of patient:

_____

Social Security Number: _____

**Please Read the Following Statements Carefully**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, and of the uses and disclosures we may make of your protected heath information and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:
**Skiffey Family Dentistry**
**Telephone: 330-336-6611, Fax: 330-336-6612, E-mail: skiffeydds@gmail.com**
**Address: 300 Weatherstone Dr. Suite 111 Wadsworth, OH 44281**

**Right to Revoke:** You will have the right to revoke this consent at any time by giving us written notice of your revocation using the office information above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

**Signature:**
I have had full opportunity to read and consider the contents of this consent form and the Notice of Privacy Practices. I understand that, by signing this consent form I am giving my consent for use and disclosure of my protected health information to carry our treatment, payment activities and health care operations.

Signature: _____ Date:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

# AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

**Name of Patient:** _____

## *Use and Disclosure of Health Information*

I hereby authorize Skiffey Family Dentistry to release all health information pertaining to my medical history, mental or physical health and information regarding treatment received and financial obligations to:

_____

Name

_____

Relationship

_____

Phone Number

**I authorize any information to be left on a voicemail regarding any treatment or diagnosis that pertains to my condition:**

☐ I authorize a detailed voicemail with health information to be left on my personal voicemail and/or the personal voicemail of authorized persons listed above

☐ I DO NOT wish to have ANY of my health information left on a personal voicemail

## *My Rights*

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of
- I may revoke this authorization at any time, but I must do so in writing and submit to the following address: 300 Weatherstone Dr. Suite 111, Wadsworth, OH 44281

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. I have the right to receive a copy of this authorization.

## *Signature*

Signature: _____
**(Patient/legal representative)**

If signed by a person other than the patient, indicate relationship: _____

Printed Name of legal representative: _____

Date: _____