Jane Otto Family Dentistry
11521 Gravois Road
St. Louis, MO 63126
(314) 842-2442

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other: _____

Social Security #: _____ Date of Birth: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Occupation: _____

In Case of Emergency: _____ Phone: _____ Relation: _____

Whom may we thank for referring you to this office? _____

HEALTH INFORMATION

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting/Dizziness
- ☐ Glaucoma
- ☐ Growths (oral)
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Radiation/Chemo
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Aspirin Therapy
- ☐ Codeine Allergy
- ☐ Latex Allergy
- ☐ Penicillin Allergy
- ☐ Taking Blood Thinners
- ☐ Smokeless Tobacco
- ☐ Smoker

Women: Are you pregnant? Due Date: _____ Taking birth control? ☐ Yes ☐ No

Do you currently take or have you ever taken bisphosphonate medications? ☐ Yes ☐ No

LIST ALL MEDICATIONS: _____

_____

_____

_____

_____

PHYSICIAN INFORMATION

Name of Primary Care Physician: _____ Phone: _____

Date of last physical exam: _____

Name of Orthopedist: _____ Phone: _____

Date of last visit: _____

Name of Cardiologist: _____ Phone: _____

Date of last visit: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

DENTAL HISTORY

Reason for today's visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ Is your mouth often dry?
- ☐ Do you have a bad taste in your mouth?
- ☐ Are your teeth sensitive to sweets?
- ☐ Are your teeth sensitive to cold/heat?
- ☐ Do your gums bleed when you brush/floss?
- ☐ Do you clench or grind your teeth?
- ☐ Does food pack between your teeth?
- ☐ Does your jaw click/pop when chewing?
- ☐ Have you ever had a "deep cleaning" ?
- ☐ Excessive bleeding after an extraction?
- ☐ Had an adverse reaction to anesthetic?
- ☐ Excessive pain or swelling after dental treatment?
- ☐ Have you been told you have periodontal disease?

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

Name of prior dentist: _____ Date of last dental visit: _____

Last time x-rays were taken: _____

Last professional dental cleaning & oral cancer screening: _____

INSURANCE INFORMATION

PRIMARY

Name of Subscriber: _____

Subscriber's DOB: _____ SSN#: _____

Employer's Name: _____ Group #: _____ ID# _____

Dental Insurance Carrier Name: _____ Phone# _____

Address: _____ City: _____ State: _____ Zip: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY

Name of Subscriber: _____

Subscriber's DOB: _____ SSN#: _____

Employer's Name: _____ Group #: _____ ID# _____

Dental Insurance Carrier Name: _____ Phone# _____

Address: _____ City: _____ State: _____ Zip: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, dental insurance coverage, or address and contact phone numbers, I will inform Dr. Otto and staff at my next appointment.

_____ Date: _____

Signature of patient, parent or guardian:

CONSENT FOR SERVICES

As a condition of your dental treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

_____ In compensation for the professional services rendered to me, at my request, by the Doctor, I agree to pay the usual and customary rate (UCR) of said services to said Doctor at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to by me in writing within thirty days. I further agree to pay all costs, attorney and court fees should my account be turned over to collections or attorney should a suit be instituted. I grant my permission to the Doctor or assignee, to telephone me at home, on my cell phone or at my work to discuss matters related to this account.

_____ Emergency dental services are payable in cash. For patients who carry dental insurance, all deductibles and co-pays must be paid for at the time services are performed. This office will help prepare the patient's insurance forms and assist in collecting insurance benefits. However, this office cannot render services on the assumption that dental fees will be paid by the insurance company. Patients who carry dental insurance understand that all dental services furnished are charged directly yo yhr financially responsible party and that he or she is ultimately, personally responsible for payment of all dental services.

_____ A service charge of $25.00 per month will be charged on all accounts receivable exceeding 30 days past due. A service charge of $25.00 will apply on returned checks in addition to the check amount.

This is a small dental office that schedules and dedicates individual time for our patients. We ask that patients alert this office at least 48 hours in advance if an appointment needs to be broken.

I have read the above conditions of treatment and payment and hereby agree to their content.

_____ Date: _____

Signature of guarantor of payment, guardian, responsible party

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Our Legal Duty:
We are required by applicable federal and state law to maintain the privacy of your health information. Protection of patient privacy is important to our office. This notice summarizes the privacy practices that will be followed at our office, and your rights concerning your health information. This Notice applies to health information collected by our office.

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 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 a new Notice available for review.

Uses and Disclosures of Health Information:
We use and disclose your health information about you for treatment, payment, and healthcare operations. We may use or disclose your health information to another dentist, physician, or other healthcare provider providing treatment to you. We may also use and disclose your health information to obtain payment for services we provided you.

Unless you give us a written authorization, we cannot use or disclose your health information for any other reason except those described in this Notice. 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 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.

We must disclose your health information to you, as described in the Patient Rights section of this Notice. With your permission, 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.

We will use our professional judgment and our experience with common practice to make reasonable inferences of your best inte rest in allowing a person to pick up dental supplies, appliances, or x-rays.

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

We may disclose your health information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, or domestic violence. 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.

We may use or disclose your health information to provide you with appointment reminders, such as voicemail, emails, postcards, or letters.

Patient Rights:
You have the right to look at or get copies of your health information, with limited exceptions. We reserve the right to charge for copies of charts, x-rays and postage of material.

You may request that we place 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 an emergency). You may request that we communicate with you by alternative means. Your request must be in writing and specify the alternate means.

Acknowledgement of Receipt of Notice of Privacy
I hereby acknowledge that I had an opportunity to review the Notice of Privacy of Jane A. Otto Family Dentistry.

Signature of Patient or Representative: _____ Date: _____

Printed name of Patient or Representative: _____

OFFICE USE ONLY. LEAVE THIS SPACE BLANK.