RESET FORM

Benjamin K. Metz D.M.D., M.S.D., LLC
Periodontics & Implantology

CREATING FOUNDATIONS

PATIENT INFORMATION

Date_____SS/HIC/Patient ID #_____

Patient _____

Address_____

City_____

State_____ Zip_____

Email_____

Sex ☐ M ☐ F Age_____

Birth Date_____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partner for_____Years

Occupation _____

Patient Employer/School_____

Employer/School Address _____

_____

Employer/School Phone _____

Spouse's Name_____

Birth Date_____

SS#_____

Spouse's Employer_____

Whom may we thank for referring you?_____

DENTAL INSURANCE

Who is responsible for this account?_____

Relationship to patient _____

Insurance Co. _____

Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_____

Birth Date_____SS#_____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurace coverage with:

_____and assign directly to
Name of Insurance Company(ies)

Dr. Benjamin Metz all insurance beneifits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Metz may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benifits or the benifits payble for related services. This consent ends when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please Print name of Patient, Parent, Guardian or Personal Representative

_____
Date Relationship to Patient

PHONE NUMBERS

Home_____ Work _____Ext_____ Cell _____

Spouse's Work _____ Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name_____ Relationship_____

Home _____ Work _____Ext_____

DENTAL HISTORY

Reason for today's visit_____

_____

Referring Dentist_____

City/State_____

Date of last dental visit_____

Date of last X-rays_____

Mark the "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken filling	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain while brushing	☐ Yes	☐ No
Orthodotic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in mouth	☐ Yes	☐ No

How often do you floss?_____

How often do you brush?_____

HEALTH HISTORY

Physician's Name_____Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Lonimin, Adipex, Fasten (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Mark the "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No		
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No		
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No		
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No		
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No		
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No		
Back Problems	☐ Yes ☐ No	Hepatitis Type_____	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No		
Bleeding Abnormally with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No		
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No		
Cancer	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No		
Chemical Dependency	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No		
Chemotherapy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No		
Circulatory Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Turberculosis	☐ Yes ☐ No		
Congenital Heart Lesions	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth (head or neck)	☐ Yes ☐ No		
Cortisone Treatments	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No		
Cough, persistant or bloody	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No		
Ephysema	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No				
		Radiation Treatment	☐ Yes ☐ No				

Do you wear contact lenses? ☐ Yes ☐ No

WOMAN:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

_____

Pharmacy Name_____

Address _____ Phone_____

ALLERGIES

Please indicate if you are allergic to any of the following:

☐ Aspirin ☐ Barbituates (Sleeping Pills) ☐ Codeine ☐ Iodine ☐ Latex ☐ Local Anesthetic ☐ Penicillin ☐ Sulfa

☐ Other_____

Westerville Periodontics and Implantology

Dr. Benjamin Metz

NOTICE OF PRIVACY PRACTICES

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to *Dr.Benjamin Metz.*

Dr. Benjamin Metz Legal Responsibilities: As mandated by Federal and State legal requirements your protected health information must be protected. As part of these regulations we are required to ensure you are aware of privacy policies, legal duties and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced and becomes effective 02/01/2006.

We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing this notice will precede all significant modifications. This notice will be available upon request.

Copies of this notice are available at your request. For your convenience information regarding how you can contact us is at the bottom of this notice.

PROTECTED HEALTH INFORMATION USE AND DISCLOSURE: Information regarding your health may be used and disclosed for the purpose of treatment, payment and other healthcare operations. Examples cited below further explain the use and disclosure process.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provider providing treatment to you.

Payment: Your protected health information may be used and disclosed to obtain payment for services we provided to you.

Healthcare Processes: We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: At any time you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization it will not affect any use or disclosure prior to the revocation.

Your protected health care information may be used and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

Person Involved in Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information may be used or disclosed to a family member, your personal representative or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without you're written authorization.

Required by Law: Your protected health information may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect or domestic violence or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

National Security: Under some circumstances the military may require disclosure of health care information for armed forces personnel. For the purpose of national securities activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected health care information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

Appointment Reminders: Your protected health care information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters.

PATIENT RIGHTS

Access: At all times you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a *Protected health information Access Form* by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you .25 for each page and $20 per hour for staff time to locate and copy your protected health information. Postage will be included if you wish to have your information mailed. If you request a format option, which is different, we will charge a cost based fee for that format. An explanation of fees can be made available.

Disclosure Accounting: Your rights include the choice to receive a review of every time we or our business associates disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years but not before April 14, 2003. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

Restrictions: You may request we apply additional restrictions to any disclosure of your health care information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions we will follow the agreed restrictions unless an emergency situation dictates otherwise.

Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or others locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject you request.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

QUESTIONS AND COMPLAINTS

More information is available to you regarding our privacy policies, please contact us.

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative locations, you have the right to bring this issue forward. You may make a 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 Service at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources we will not retaliate in anyway. We are available to assist you with any questions, concerns or complaints.

Contact Person's Name: Susan Bagley

Telephone: 614-882-5050

Fax:: 614-882-5087

Address: 891 Eastwind Drive

City, State, Zip: Westerville, OH 43081

Acknowledgement of Receipt of Notice of Privacy Policies

I, _____, have received / or been offered a

copy of _____Dr. Metz_____'s Notice of Privacy Policies.

_____
Name (print)

_____ _____
Signature Date

OFFICE USE ONLY

On _____, an *Acknowledgment of Receipt of Notice of Privacy Policies* form was delivered. The form was not signed due to:

- ❑ Communication barriers which prevent acknowledgement
- ❑ An emergency which prevent acknowledgement
- ❑ A refusal to sign
- ❑ Other _____

Benjamin K. Metz D.M.D., M.S.D., LLC
Periodontics & Implantology

FINANCIAL POLICY

Thank you for choosing us as your dental specialist. It is our goal to provide quality care to our patients. Your understanding of our office policies is important to our professional relationship. Please read the financial policy, then sign and date it.

* Provide current personal information at the initial visit
* Provide a current insurance card at each visit and notify the office with any changes in your insurance coverage
* Payment of your estimated co-payment at each visit
* Prompt payment of any outstanding balance
* Payment of today's visit if you do not have insurance coverage Initial_____

Insurance Coverage

Your insurance plan is a contract between you and your carrier, and we are not party to that contract. While filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date services are rendered. In order for our office to correctly file a claim we must have a current insurance card at each visit let us know of any changes in your personal information.

Our office will file with your insurance company as services are rendered, and if your insurance carrier fails to respond to the initial claim we will resubmit your claim one additional time to attempt to recover their payment. If your insurance carrier fails to pay the second submission you will be responsible for the entire balance on your account.

Initial_____

Financial Policy

*** A deposit is required at the time of scheduling all appointments which require one hour or more to complete. This deposit will hold the allotted time for your procedure and will apply to any payments due at the time of your dental procedure. Please note that failure to give a 48-hour (business hours) cancellation notice will result in forfeiture of the deposit.**

Initial_____

- Checks returned NSF (Non-Sufficient Funds) will be subject to a $30.00 fee (in addition to charges from your bank)
-

* Collection Fee- A 1.5% monthly finance charge will be added to your monthly statement for any late payments. If your account is 90 days past due, you will be given a 30 day notice. At the end of the 30 days, all portions due (not including insurance pending) will be sent to an outside collection agency. Please note that an additional 30% collection fee will be applied to your balance at this point.

Initial_____

_____ _____

Responsible Party Signature Date

Benjamin K. Metz D.M.D., M.S.D., LLC

Periodontics & Implantology

CREATING FOUNDATIONS

Patient Name _____

To help us better assist you, please rank the following statements in the order of importance to you. With **(1)** being the most important to you continuing to **(5)** being the least important to you, using each number only once!

Example:

___1___ Finances are a major factor when considering what dental treatment I choose.

___3____ I associate dental work with Fear/Pain/Anxiety

___5_____ A great smile is most important to me.

___2_____ Longevity/value is what I am looking for when I choose between treatment options.

____4____ As long as my teeth function, aesthetics really are not a concern.

_____ Finances are a major factor when considering what dental treatment I choose.

_____ I associate dental work with Fear/Pain/Anxiety

_____ A great smile is most important to me.

_____ Longevity/value is what I am looking for when I choose between treatment options.

_____ As long as my teeth function, aesthetics really are not a concern.