

Welcome to our office! In order to get to know you better and to give you the most consideration of your time, please complete all sections of this form. All information is, of course, confidential.



Dr. Robin C. Ford DDS, Inc.
6890 Perimeter Drive, Suite A
Dublin, OH 43016
614-761-1974 ♦ Fax 614-798-1520
E-Mail: fordfamilydental@aol.com
Website: www.fordfamilydental.com

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I.: _____
Preferred First Name: _____ Date of Birth: _____ Social Security No.: _____
Address: _____ City: _____ State: _____ Zip Code: _____
E-Mail: _____ Communication preference: E-Mail Text Phone (check all that apply)
Home Phone: _____ Work Phone: _____ Mobile Phone: _____
Employer: _____ Occupation: _____
 Minor Child Single Married Divorced Widowed

PERSONAL RESPONSIBLE FOR ACCOUNT – RELATIONSHIP TO PATIENT _____

Last Name: _____ First Name: _____ M.I.: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____ Mobile Phone: _____
Date of Birth: _____ Social Security No.: _____ E-Mail: _____
Employer: _____ Occupation: _____
Spouse's Name: _____ Date of Birth: _____
Social Security No.: _____ E-Mail: _____
Employer: _____ Occupation: _____

DENTAL INSURANCE: Yes No

SECONDARY INSURANCE: Yes No

Insured Person: _____
Insurance Company: _____
Subscriber ID: _____
Group Number: _____
Insurance Company Contact Information _____

Insured Person: _____
Insured Person: _____
Subscriber ID: _____
Group Number: _____

EMERGENCY INFORMATION

In case of an emergency whom should we contact: _____
Relationship to patient: _____ Telephone Number: _____

HEALTH HISTORY

Are you aware of any particular dental problems? _____ Are you having any discomfort or pain? _____
 How long has it been since you last visited a dental office? Who was your previous dentist? _____
 May we ask why you left? _____
 Has any dental treatment ever been recommended that hasn't been done? Yes No
 How do you feel about having dental work done? Dread it Worry about it Don't mind
 If you could change your smile, how would you want it to look? _____
 Your physician's name: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the dental treatment that you receive. Thank you for answering the following questions.

Are you under a physician's care now?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A _____
Have you ever been hospitalized or had a major operation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A _____
Have you ever had a serious head or neck injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A _____
Are you taking any medication, pills or drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	IF YES PLEASE LIST IN THE COMMENTS BELOW
Do you take, or have you taken, Phen-Fen or Redux?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Are you on a special diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you use controlled substances?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Women: Are you Pregnant Nursing Taking Oral Contraceptives

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other: _____

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

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Murmur * | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Pace Maker * | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve * | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Mitral Valve Prolapse * | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint * | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Herpes | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatic Fever * | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

* Condition may require pre-medication.

Have you ever had any serious illness not listed above? Yes No N/A

Comments: _____

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 _____

Date _____

DENTAL HISTORY



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Why have you come to the dentist today?

Who can we thank for your referral to our office?

If "yes", please detail below

Do you require antibiotics before dental treatment? No Yes _____

Are you currently in pain? No Yes _____

Do your gums ever bleed? No Yes _____

Have you ever had a serious or difficult problem associated with any previous dental work? No Yes _____

Do you now or have you ever experienced pain/discomfort in your jaw joint? No Yes _____

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Would you like whiter teeth? Yes No Fresher Breath? Yes No

How many times a week do you floss? _____ times a day do you brush? _____

OFFICE USE ONLY

I verbally reviewed the medical and dental information with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

**BROKEN APPOINTMENT
POLICY**



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You appointment time has been reserved especially for you. If you are unable to keep your appointment, please notify our office at least 24 hours in advance.

Our primary goal is patient care, and as a courtesy our staff will attempt to confirm your appointment, but it is the patient's (or guardian's) sole responsibility to confirm and keep scheduled appointments. Our practice also has an after-hours voicemail system that patients can utilize by calling (614) 761-1974 for the purpose of notifying us of your need to reschedule an appointment. Broken hygiene appointments, late arrivals (more than 15 minutes after your scheduled appointment) requiring re-scheduling, and appointments cancelled with less than 24 hours notice will be charged \$35 per appointment. Restorative appointments will be charged \$100 per appointed hour.

By not canceling in a timely manner, our practice is unable to fill those appointment times with other patients who are eager to be cared for in our practice. It is necessary for us to enforce this policy in order to be fair to all our current and future patients. As the demand grows for our services, this policy will decrease the waiting time for all patients and help ensure availability and prompt care. We understand that a situation may arise that may not permit you to give us adequate notice. Exceptions to this policy will be determined on an individual basis according to the circumstances.

I have read and understand the Broken Appointment Policy. By signing below, I acknowledge that I will make every effort to notify the dental staff at least 24 hours in advance if I will not be able to make my scheduled appointment. I also understand that if I break three appointments without notice, I may be asked to separate from the practice.

Patient Signature (or Guardian)

Date

Print Name

**CONSENT FOR TREATMENT
INSURANCE RELEASE
AUTHORIZATION**



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I give my permission for the dentists and staff of Dr. Robin c. Ford DDS, Inc to treat me, including any procedure(s) as deemed necessary in the exercise of their professional judgement. Please check or initial each item below:

_____ I understand that dental care requires my cooperation, and I will follow my dentist's orders and prescriptions. If indicated, I will make and keep appointments for follow-up care and call the office to note any changes or concerns in my condition.

_____ I authorize my dentist and the staff to use photography, video tape or other similar means to record my procedure(s). I understand that reproduction or publication of said photographs and recordings will be used for the purpose of insurance predeterminations, patient education, before and after dental portfolios and/or documentation for my dental record and require an additional consent/release for any publication.

_____ I further acknowledge that all recorded media obtained is the sole property of Robin C. Ford DDS, Inc. All x-rays, photos, etc. are to be maintained by Dr. Robin C. Ford DDS, Inc. as required by law. Patients are entitles to copies of any/all patient materials.

Patient Name: (Print) _____ Date: _____

Patient/Parent or Guardian's Signature: _____

Witness: _____ Date: _____

AUTHORIZATION AND RELEASE

_____ I have read and understand the consent forms that have been provided to me by the dentists and staff of Dr. Robin C. Ford DDS, Inc.

_____ I authorize my dentist to release any information, including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers.

_____ I authorize and request that my my insurance company, in lieu of reimbursing me directly, pay to the dentist or dental group any benefits for services rendered.

_____ I understand that my dental insurance carier may pay less than the actual bill for services. I agree that I may be responsible for payment of all services rendered on my behalf or my dependents.

_____ I have received, read and fully understand the financial policy and payment options for Dr. Robin C. Ford.

Signature of Patient or Parent (if Minor)

Date

FINANCIAL POLICY



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Insurance

We routinely file claims and accept insurance payments as a courtesy to our patients. Please note that some plans have yearly maximums, deductibles, waiting periods, limitations, alternate benefits, and missing tooth clauses that may limit your benefits. Consult the carrier, your Human Resources representative or your Benefit Plan book. Our staff does its best to obtain as much information about your dental plan from the insurance company, but you are ultimately responsible for knowing your coverage.

Insurance can be very confusing. We are happy to assist you in maximizing your dental benefits but your insurance is a contract between you, your employer and the insurance carrier. This is where the confusion may begin. Some patients believe that the filing, tracking and collection for their insurance rest solely on the medical or dental office. The ADA, AMA, your HR person and even your carrier will confirm that this is your insurance and you are the responsible party.

Here is some information about the dental insurance system that will help to explain why what is best for you may not always be the same as what your insurance will pay:

FACT #1: *Dental insurance differs in some ways from regular health insurance that covers physician and hospital costs. Not everyone gets ill but nearly everybody has some dental costs. The amount of money available to pay dental insurance costs is equal to the amount contributed by employees and employers minus costs of operating the insurance company and a normal company profit. So the lower your premiums for insurance the less money there is available to pay claims.*

FACT #2: *To protect themselves, insurance companies usually make up a schedule of what they view as "usual and customary fees." It is our experience in dealing with over 1,000 insurance plans that some schedules actually only cover 40-50% of customary fees. Others may cover up to 80% with certain deductibles, maximums and exclusions. Rarely does insurance cover 100%.*

FACT #3: *Since insurance companies are in business to sell insurance and make a profit, it is natural that they may try to shift the blame for their lack of coverage onto the dentist and their fee schedule rather than admitting their coverage is less than customary.*

It is very appropriate for you to call your insurance carrier and ask any questions regarding details of the insurance plan they are operating on your behalf.

We want you to be comfortable in dealing with these matters and urge you to ask us if you have any questions regarding our services and fees.

**FINANCIAL
POLICY**



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Our Protocol and Policy

We ask that you provide accurate insurance information prior to or at your initial visit. We will try to obtain as much information about your plan as the carrier will allow. You will be responsible to pay any difference between the amount covered by your insurance and your treatment costs at the time that treatment is received. We will file your claim at our expense as a courtesy. After 30 days have elapsed we will research and re-file your claim if necessary. At 30 to 45 days, we will send you a letter informing you of the problem and ask that you become involved with your insurance company. At 60 days we ask that you satisfy the balance if the insurance company has made no payment. We will re-file or appeal without any expense to you, and direct the monies to you once they have been received, since you have met your obligation to us. In the unfortunate event that any account reaches 90 days without payment we will attempt to provide you with a final notice. On the 97th day we will reluctantly forward this to an outside collection agency. ***Patients will be responsible for any and all costs incurred by Robin C. Ford DDS, Inc. should their account(s) be sent to a third party agency for the purpose of collecting any outstanding debt over 90 days.***

Patient co-payments are due on the day services are rendered to help control costs associated with billing and collections, and to comply with contractual provisions of multiple insurance carriers. For these co-payments we accept the following forms of payment: Cash, Check, MasterCard, Visa, Discover and American Express. We also offer interest free loans through Chase Health Advance financing (applications are available in the office and on our website).

Patients that elect to prepay for their portion of treatment costs at the time of scheduling are eligible to receive a 5% discount on their cost of treatment.

Patient Signature (or Guardian)

Date

Print Name

HIPAA PRIVACY POLICY



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This notice describes how personal health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to you individually identifiable health information.

It is the policy of our practice that the dentist and staff preserve the integrity and confidentiality of Protected Health Information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its dentists and staff have the necessary medical and PHI to provide the highest quality dental care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its dentists and staff for the purpose of Treatment, Payment and dental Operations (TPO). To that end, our practice, its dentists and staff will:

1. Adhere to the standards set forth in the Notice of Privacy Practices.
2. Collect, use and disclose PHI only in conformance with state and federal laws, and current covenants and/or authorization from the patient (or parent/guardian).
3. Remind patients of their appointments and file insurance on their behalf unless they instruct us not to do so.
4. Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice, its dentists and staff will implement reasonable measures to protect the integrity of all PHI maintained about patients.
5. Recognize that patients have a right to privacy. Our practice and its dentists and staff respect the patient's individual dignity at all times. Our practice and its dentists and staff will respect the patient's privacy to the extent consistent with providing the highest quality dental care possible and with the efficient administration of the facility.
6. Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its dentists and staff will:
 - a. Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
 - b. Not disclose PHI data unless the patient (or his/her authorized representative) has properly authorized the release, or the release is otherwise authorized by law
7. Recognize that although our practice "owns" the dental records, the patient has the right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her dental record if he/she believes his/her information is inaccurate or incomplete. Our dentists and staff will:
 - a. Permit patients' access to their dental records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site dental professional review the patient's appeal.
 - b. Provide patients an opportunity to request the corrections of inaccurate or incomplete PHI in their dental records in accordance with the law and professional standards.
8. The dentist and staff of our practice will maintain a list of certain disclosures of PHI for the purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPPA rule. We will provide this list to patients upon request, so long as their requests are in writing.
9. The dentists and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that our patients have requested and have been approved by our practice.
10. The dentists and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.
11. The dentists and staff of our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

**HIPAA
CONSENT**



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I give permission to the doctors and staff of Robin C. Ford DDS, Inc. to leave voicemail messages concerning my appointments and any appointments for my dependant children. I understand it is my responsibility to inform the office of any changes in this information. Please leave information at the following phone numbers:

Primary Number: _____	Home	Work	Cell	Other
Secondary Number: _____	Home	Work	Cell	Other
Other Number: _____	Home	Work	Cell	Other

I also give permission to mail reminder postcards regarding appointments to my home address. This includes postcards for any dependant children and myself. I understand it is my responsibility to inform the office of any changes in this information.

Home Address: _____
City: _____ State: _____ Zip Code: _____

Child(ren)'s or ward(s) name(s) is/are: _____

I also acknowledge that I have received a copy of and understand the HIPAA Privacy Policy for Robin C. Ford DDS, Inc.

Patient, Parent or Guardian Signature

Date

Relationship to Patient