Today's Date: _____

Robin C. Ford, DDS ◆ 6890 Perimeter Dr, Suite A ◆ Dublin, OH 43016
614-761-1974 ◆ fax: 614-798-1520 ◆ email: info@fordfamilydental.com

Welcome to the office of Robin C. Ford, DDS! In order to get to know you better and in consideration of your time, please complete all sections below. All information is of course, confidential. Thank you!

PATIENT INFORMATION

Patient First Name:	Last:	M.I:	Preferred Name:
Date of Birth: / /	Social Security No:	Home Phone: ( )	Cell Phone: ( )
Email:	Preferred Communication (check all that apply): Email ❑ Text ❑ Phone ❑		
Address:	City:	State:	Zip Code:
Occupation:	Employer:	Work Phone: ( )	
Marital Status: ❑ Single	❑ Married	❑ Divorced	❑ Widowed ❑ Minor

PERSON RESPONSIBLE FOR ACCOUNT: (if self, check here ❑)

Relationship to Patient:	First Name:	Last:	M.I:
Date of Birth: / /	Home ❑ Cell ❑	Email:	
Address:	City:	State:	Zip Code:
Occupation:	Employer:	Work Phone: ( )	

DENTAL INSURANCE: Yes ❑ No ❑

Company:	Phone No: ( )	Group No:
Subscriber:	Date of Birth: / /	Member ID/SSN:
Secondary Insurance Company:	Phone No: ( )	Group No:
Subscriber:	Date of Birth: / /	Member ID:SSN:

EMERGENCY CONTACT:

ICE Contact:	Phone No: ( )	Relationship to Patient:

Who can we thank for your referral to our office?

HEALTH HISTORY:

Are you under a physician's care currently? Yes ❑ No ❑
If yes, please let us know the doctor's name:

Have you ever been hospitalized or had a major operation?	Yes ❑	No ❑	
Have you ever had a serious head or neck injury?	Yes ❑	No ❑	
Are you taking any medication, pill, or drugs?	Yes ❑	No ❑	* If yes, please list below
Do you take, or have you taken, Phen-Fen or Redux?	Yes ❑	No ❑	
Are you on a special diet?	Yes ❑	No ❑	
Do you use tobacco?	Yes ❑	No ❑	
Do you use controlled substances?	Yes ❑	No ❑	

If you answered yes to any of the above, please explain in the section below, including the medications you are taking:

Women: Are you: Pregnant ❑ Nursing ❑ Taking 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?

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

Have you ever had any serious illness not listed above? Yes ❑ No ❑ If yes, please explain:

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:

Last dental visit:	Previous dentist:	May we ask why you left?

Any dental work 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 ❑

Are you aware of any dental problems?
Yes ❑ No ❑

Are you in discomfort/pain now?
Yes ❑ No ❑

Do your gums ever bleed?
Yes ❑ No ❑

Do you or have you experienced jaw pain or discomfort?
Yes ❑ No ❑ If yes, please explain:

Have you ever had a serious problem associated with any previous dental work? Yes ❑ No ❑
If yes, please explain:

Do you require antibiotics before dental treatment? Yes ❑ No ❑	If yes, please explain:

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?	How many times a day do you brush?

Your current dental health is:
Good ❑ Fair ❑ Poor ❑

FOR OFFICE USE ONLY
I verbally reviewed the medical and dental information with the patient named herein. Initials: Date Comments:

FINANCIAL & INSURANCE POLICY:

❑ I authorize my dentist and the staff to use photography, video tape, or other similar means to record my procedures. I understand that reproduction or publication of my information will be used for the purpose of insurance predeterminations, patient education, and/or documentation for my dental record and require an additional consent/release for any other publication. All recorded media obtained is the sole property of Robin C. Ford, DDS, Inc. and are to be maintained as required by law. Patients are entitled to copies of any/all patient materials.

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, and missing tooth clauses that may limit your benefits. We will try our best to provide as much information about each plan, but it is ultimately the patients' responsibility to know their plan and benefits.

❑ I will provide accurate insurance information prior to or at initial visit. Any difference between the amount covered by insurance and remaining treatment costs is my responsibility and will be paid at time of service.

Signature of patient, parent, or guardian **Date**

BROKEN APPOINTMENT POLICY

❑ Your appointment has been reserved especially for you. If you are unable to keep your appointment, please notify our office at least 48 hours in advance. By not canceling in a timely matter, our practice is unable to fill those appointment slots with other patients who are eager to be cared for in our practice. 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. It is your responsibility to confirm and keep scheduled appointments, but we will attempt to confirm your appointment by email/text reminders and phone calls. Our practice also has an after-hours voicemail system that you can utilize by calling 614-761-1974.

❑ Broken hygiene appointments, late arrivals (more than 15 minutes after scheduled appointment) requiring rescheduling, and appointments cancelled with less than 48 hour notice will be charged $50 per appointment. Restorative appointments will be charged $100 per hour.

Signature of patient, parent, or guardian **Date**

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

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

❑ I understand that the staff of Robin C. Ford, DDS will try their best to obtain as much information about my dental plan from the insurance company, but it is ultimately my responsibility to know my own plan and benefits.

❑ I have read and understand the consent forms that have been provided to me.

Signature of patient, parent, or guardian **Date**

HIPAA PRIVACY POLICY

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, it's 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.

HIPPA

CONSENT

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

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 entitled 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 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 carrier 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:

Sept 13,2023

To Our Patients:

Effective October 1, 2023 our office will be switching from paper billing to electronic billing. We are making this change to provide improved patient communication as well as provide more convenient payment options.

What we need from you:
-We will need your authorized consent to be able to send you electronic billing.
-Indicate your preference of receiving TEXT or EMAIL billing below and fill out the needed info.

By signing this form and providing my cell phone information or email address, I am willing to receive my account statements as well as respond with a secure method of payment.

Patient's Signature: _____

Patient's Cell Phone or Email: _____

Please return this completed form to our office in a timely manner.

Sincerely,

Robin C Ford DDS