

EMERGENCY PATIENT INFORMATION (Confidential and Necessary) Date: __/__/__

Name: _____ **Birth Date:** ____/____/____ **Age:** ____

Home Address	City	State
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Zip _____

Phone Numbers: Home - - Work - - Cell - -

e-Mail Address _____ **@** _____ **Social Security Number:** - -

[illegible]

Employer Address	City	State	ZIP
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Spouse/Parent/Guardian (circle one) _____

Their Employer	Position	How
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Long? _____

Their Employer Address _____ **City** _____ **State** _____

ZIP _____

Nearest Relative Not Living With You	Relationship

9	City	State
Their Phone Number - -		

Whom Should We Contact In An Emergency? Phone: - -

Physician _____ Phone: _____ - _____ - _____

Person Responsible For This Account _____ (signature)

Craig Callen D.D.S. & Associates

DENTAL INSURANCE INFORMATION (TO PROCESS YOUR CLAIM)

Primary Dental Ins. Co.	Employer	Group
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Phone	-	-	Annual Benefit Maximum	Annual Deductible
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Whom May We Thank for This Referral (How did you find out about us?)

Reason For Call: _____ Discomfort, How long? _____ Swelling _____ Broken Tooth/Filling
 _____ Bleeding _____ Toothache _____ Sensitive to: Hot Cold Sweet Biting

Comments:

Location of Problem:	☐ Upper Right ☐ Upper Left ☐ Lower Right ☐ Lower Left				
Fee Range Given: \$	to \$	Payment Method:	Cash	Check	Credit Card

Date**Tooth#**

Treatment Notes

Emergency Exam

X-Ray Flim #

Panorex

Rx: Antibiotic: Pain Meds:

Other:

Refer To:

CAESY:

PATIENT MEDICAL HISTORY

Date: / / Blood Pressure: /
(taken by our office)

MEDICAL ALERTS !

Patient Name:

Age:

Weight:

Height:

- | | | |
|---|-----|----|
| 1.) Have you been hospitalized in the last 5 years? Why? _____ | YES | NO |
| 2.) Are you taking any medications? What? _____ | YES | NO |
| 3.) Are you allergic to any medications? What? _____ | YES | NO |
| 4.) Do you use alcohol? How much a week? _____ | YES | NO |
| 5.) Do you use tobacco products? How much a day? _____ | YES | NO |
| 6.) Have you had any allergies or problems with Novocaine? _____ | YES | NO |
| 7.) Have you had any allergies to Latex? _____ | YES | NO |
| 8.) Do you have any problem bleeding a long time if you cut yourself? _____ | YES | NO |
| 9.) WOMEN: Are you pregnant, or think you may be? What month? _____ | YES | NO |
| Are you taking birth control pills? _____ | YES | NO |

10.) IF YOU HAVE HAD ANY OF THE FOLLOWING PROBLEMS, PLEASE CIRCLE THE CORRECT RESPONSE. IF SOMEONE IN YOUR FAMILY HAS HAD THE PROBLEM, PLEASE WRITE AN "F" FOR FAMILY NEXT TO THE CORRECT RESPONSE. THANK YOU.

Heart Disease or Attack
Angina (Chest Pain)
Heart Murmur
Mitral Valve Prolapse
Artificial Valve
Pacemaker
High Blood Pressure
Low Blood Pressure
Swollen Ankles
Anemia
Thyroid Disease
Glaucoma

Jaundice or Liver Disease
Hepatitis A
Hepatitis B
Hepatitis Non A,B
A.I.D.S. or H.I.V.
Blood Transfusion
Hemophilia
Venereal Disease
Sinus Problems
Asthma
Hay Fever/ Allergies
Ulcers

Diabetes
Tuberculosis
Arthritis
Rheumatism
Artificial Joints (or pins)
Cancer
Radiation Therapy
Chemotherapy
Drug or Alcohol Problems
Psychiatric Treatment
Fainting or Dizziness
Epilepsy

NOTES:

- | | | |
|---|-----|----|
| 11.) Do you get shortness of breath, or chest pain walking up stairs? _____ | YES | NO |
| 12.) Do you need to prop yourself up with pillows to sleep? _____ | YES | NO |
| 13.) Do you have any health problems not listed? What? _____ | YES | NO |

To the best of my knowledge, all of the preceding answers are true and correct. I will inform the doctor if there are any changes in my health, or medicines at my next appointment. I am also now aware that the doctor may take pictures for diagnosis and documentation purposes and that I give my permission for these pictures to be used for educational and scientific purposes. I authorize the insurance company to pay the dentist benefits payable to me for services rendered and authorize the use of this signature for insurance submission. I authorize release of information to the insurance company. I understand that I am financially responsible for my treatment regardless of what my insurance may or may not pay.

Patient (Parent) Signature: _____

Dr. _____

Craig C. Callen, D.D.S. & Associates

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy as a patient. Implementation of HIPAA requirements officially began on April 14, 2003. While we have followed these policies for years, there have been a few updates that we wanted you to be aware of. This is a shortened version of the HIPAA policy. The full policy is available for your review if you would like.

There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal exchange of information within our office. HIPAA provides certain rights and protections to you as the patient. We follow these guidelines and provide you with the quality care you deserve. Additional information is available from the U.S. Department of Health and Human Services. You can find them online at www.hhs.gov

This summarizes our policy here at Craig C. Callen, D.D.S. & Associates.

Patient information will be kept confidential except when it is necessary to provide services or to ensure that all administrative matters related to your care are handled properly. This may include, but not limited to, the sharing of information with other healthcare providers, laboratories, and health insurance companies. Patient information (treatment plans, insurance forms, eob's etc.) may be stored in file cabinets not accessible by patients. Preparing for and during your dental visit such records may be left, at least temporarily, in administrative areas such as the front office, doctors desk, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

We send out reminders to our patients. We do this by one or more of the following; e-mail, texting, calling, and sending postcards. We try to make every effort to remind you of your appointment and any treatment that you need. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative. We also may send out newsletters or special promotions that we are offering.

You agree to us sending electronic e-referrals to specialists, which include your PHI and x-rays, if needed. We also send electronic claims to your dental insurance, which includes submitting PHI to receive payment for services provided.

You give us permission to remind you to take pre-medication prior to appointments, if applicable.

You give us permission to call in any prescriptions you may need and share your PHI with the pharmacist.

The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor, and understand that you have the right to file a complaint. We can help you do this, and you will not be penalized for filing a complaint.

Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services without your permission.

We agree to provide patients with access to their records in accordance with state and federal laws. We may update this policy as needed to better serve the needs of our patients and our practice.

By signing below, I agree that, I have been offered the HIPAA policy, and understand and acknowledge my agreement to the terms set forth in the HIPAA information and consent form and any future update to this policy.

Patient: _____

Signature: _____

Date: _____

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize Craig C. Callen & Assoc. L.L.C. to disclose your PHI to the following individuals (check all that apply).

Name: _____ Relationship to Patient: _____

Telephone: (____) _____ Email: _____

Types of Information: ☐ Appointment Reminders ☐ Results (X-Ray, etc) ☐ Financial ☐ Other: _____

Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: _____

Name: _____ Relationship to Patient: _____

Telephone: (____) _____ Email: _____

Types of Information: ☐ Appointment Reminders ☐ Results (X-Ray, etc) ☐ Financial ☐ Other: _____

Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: _____

Name: _____ Relationship to Patient: _____

Telephone: (____) _____ Email: _____

Types of Information: ☐ Appointment Reminders ☐ Results (X-Ray, etc) ☐ Financial ☐ Other: _____

Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: _____

☐ None of the above

Signature: _____

Dr. Craig Callen & Associates

552 South Trimble Road

Mansfield, Ohio 44906

DELINQUENT ACCOUNT:

Any delinquent account may be placed with a collection agency if we are unable to work out a financial solution. Accounts placed with a collection agency will be assessed an additional charge up to 1.5% per month. If your account is placed with a collection agency and legal action is initiated, you will be responsible for any amount due, including but not limited to interest, fees, and/or expenses incidental to the principal obligation prior to a judgment being rendered against you.

BROKEN APPOINTMENTS:

When you miss an appointment or change on short notice, it affects many people. The time is reserved just for you. Missed appointments delay your treatment, but it also takes time away from other patients and leads to higher overhead and increased fees. **We request a two day notice of any change.**

Our policy is:

1st broken appointment/short notice change - We will waive our usual \$100 missed appointment/late cancellation fee. **We request a two day notice of any change.**

2nd broken appointment/short notice change - A \$100 charge will be reflected on your statement and a \$100 deposit for reserving your next appointment time.

3rd broken appointment/short notice change - A \$100 charge on your statement plus a \$100 deposit for reserving your next appointment time. If you are unable to keep this appointment and do not give us at least 2 business days notice you will forfeit this deposit.

Of course, we understand there are legitimate reasons patients have to occasionally miss appointments. Every situation will be weighed on its own merits.

Thank you for understanding our policy and for your consideration.

I/We the undersigned acknowledge and agree to the terms and conditions of Craig C. Callen, D.D.S. & Associates including but not limited to the fees and conditions contained herein.

Patient Signature _____ Date _____

Updated 3/2022