Amber L. Ausnehmer D.D.S., LLC

3700 Stutz Drive #2 • Canfield, OH 44406

(330) 702-0346
dramberdentistry.com

New Patient Instructions

New Patient Paperwork Instructions:

The following forms must be filled out for each patient scheduled:

- New Patient Registration
- Health History (please fill out the appropriate form: Adult or Pediatric)
- Medication List (please provide medications and reasons for taking, for Adults and Children)
- HIPPA form

All forms must be received by our office no later than 7 days prior to the initial new patient appointment to allow for insurance verification and completion of your chart, or your appointment will be rescheduled.

You may submit your forms in one of the 3 ways:

- Download the single PDF file that can be filled out on your phone or computer and then emailed to **drausnehmer@gmail.com**
- Print the forms and mail or drop off during business hours
- Call the office and provide the information over the phone

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Welcome to our Practice

Chart#: FOR OFFICE USE ONLY

Patient Name: Last | First | MI | Preferred Name

Title: Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: **SS#:** **Prev. Visit:**

Email Address: **Best time to call:**

Phone: Home | Mobile | Work | Ext | Fax | Other

Address: Address 1 | Address 2

City | -- State | Zip Code

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: **Phone:**

Employer Address: Address 1 | Address 2

City | -- State | Zip Code

Whom may we thank for referring you to our practice?

In an emergency who should be notified? Please enter Name and Phone number below:

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or you are the parent/guardian of the patient

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: Last | First | MI | Preferred Name

Title: Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: **SS#:** **DL#:**

Email Address: **Best time to call:**

Phone: Home | Mobile | Work | Ext | Fax | Other

Address: Address 1 | Address 2

City | -- State | Zip Code

Primary Dental Insurance:

Name of Insured: Last | First | MI

Insured's Birth Date: **ID #:** **Group #:**

Insured's Address: Address 1 | Address 2

City | -- State | Zip Code

Insured's Employer Name:

Employer Address: Address 1 | Address 2

City | -- State | Zip Code

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

Insurance Plan Name:

Insurance Address:

Address 1 | Address 2

City | -- State | Zip Code

Insurance Company Phone Number:

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Previous Dentist Name and Phone Number:

Date of most recent dental exam and dental x-rays:

Consent for Services and Financial Policy

WHAT YOU NEED TO KNOW ABOUT YOUR DENTAL INSURANCE BENEFITS:

Your dental insurance coverage is a benefit that will help you pay for your dental treatment. The contract you have with your dental insurance carrier is between you and your carrier and it is your responsibility to be aware of your coverage. You have a yearly maximum and may have a yearly deductable that applies mostly to basic and major servics. You may owe additional fees if your carrier's allowed amount and the fee for servics rendered are different. Your insurance company's disclaimer says they do not guarantee payment for services rendered until the claim is received and reviewed. Thereore we also cannot guarentee what they will cover. The co-insurance amount we ask you to pay is estimated from past payments received and the percentags offered by your benefit carrier.
I agree to pay for services rendered at time of service. Any balance remaining after insurance payment will be invoiced.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.**

Cancellation Policy

We have reserved appointment time for you, which is valuable. Therfore, if you do not cancel your appointmenet 24 hrs in advance, or miss your scheduled appointment, there wil lbe a fee of $25.00 chareged to your account.

☐ * **By checking this box, I acknowledge I have read this statement and agree to the contents.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting,

disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ * **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.**

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Adult Health History

Patient Name: Last | First | MI | Preferred Name

Patient Date of Birth 12/10/2023

Primary Physicians Name and Phone Number

Specialist Physicians Name and Phone Number

Pharmacy Name and Phone Number

Allergies

Are you allergic to, or have you reacted adversely to the following:

- ☐ Latex
- ☐ Aspirin
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Codeine
- ☐ Local Anesthetics
- ☐ Milk or nuts
- ☐ Red dye

Other: Please list

Did you or do you have:

- ☐ Endocarditis
- ☐ Heart Valve Replacement
- ☐ Rheumatic Fever
- ☐ Congenital Heart Defect
- ☐ Knee or Hip Replacement
- ☐ Implant / Prosthetic / Other
- ☐ Asthma
- ☐ Diabetes
- ☐ Seizures
- ☐ Hyperthroidism
- ☐ Hypothyroidism (low)

If diabetic, what is your typical blood sugar range?

- ☐ HIV / Aids
- ☐ Venerial Disease
- ☐ Tuberculosis
- ☐ Hepatitis

If you have hepatitis, what type?

- ☐ A
- ☐ B
- ☐ C
- ☐ D
- ☐ E

☐ Pacemaker ☐ High Blood Pressure ☐ Smoke now or in the past ☐ Smokeless tobacco
☐ Heart Attack ☐ Stroke

☐ Abnormal Bleeding associated with previous surgeries or dental extractions
☐ Blood Disorder

If yes, please list type of blood disorder:

☐ Renal Failure ☐ Dialysis ☐ Cirrhosis/ Liver disease

Other Kidney Disease / Disorder?

Do you drink more than 4 drinks on any given day? ◯ Yes ◯ No

☐ Stomach ulcers ☐ Acid Reflux ☐ Colitis/ Diverticulitis/ Crones Disease

☐ Sjogren's Syndrome ☐ Scleroderma ☐ Myasthenia Gravis ☐ Tendency to Heal Keloid

Please list any other auto immune disease or connective tissue disorder:

☐ Cancer requiring radiation to head or neck

☐ Chemical Imbalances/ Psychiatric problems ☐ Ilicit drugs

Do you want to be tested for HPV? ◯ Yes ◯ No

Do you have an interest in knowing more about Botox or Fillers? ◯ Yes ◯ No

Do you have any other disease / condition / problem not listed that you think Dr. Ausnehmer should be made aware of?

◯ * **I certify that I have read and understand the above. I will not hold Dr. Ausnehmer, or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form.**

Name of patient, parent, or guardian completing this form:

Relationship to patient:

Date Updated: 12/10/2023

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MEDICATION LIST

Patient Name: Last | First | MI | Preferred Name

Medication Name/ Dosage Reason for taking

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PEDIATRIC HEALTH HISTORY

Patient Name: Last | First | MI | Preferred Name

Date of Birth: 12/10/2023

Current weight:

Primary Physician Name and Phone Number

Specialist Physician Name and Phone Number

Pharmacy Name and Phone Number

Does you child have: (please check to indicate yes)

☐ Congenital heart defect ☐ Repaired congenital heart defect ☐ Heart valve replacement

Other Heart Condition:

Cardiologist and phone number

Is your child allergic to/reacted adversely to the following:

☐ Latex ☐ Aspirin ☐ Penicillin ☐ Sulfa drugs ☐ Codeine
☐ Local Anesthetics ☐ Milk or nuts ☐ Red Dye

Other Allergies:

☐ Hepatitis ☐ HIV/ AIDS

If your child has hepatitis, which type?

☐ A ☐ B ☐ C ☐ D ☐ E

☐ Asthma ☐ Cystic fibrosis ☐ Seizures ☐ Hyperthyroidism
☐ Hypothyroidism (low) ☐ Diabetes

If diabetic, what is your child's typical blood sugar range?

☐ Abnormal bleeding/ Blood disorder

Please list:

☐ Renal failure ☐ Dialysis ☐ Liver disease

Other kidney disease/Disorder:

☐ Stomach ulcers ☐ Acid reflux ☐ Colitis/ Diverticulits/ Chrones disease

☐ Sjogren's syndrome ☐ Scleroderma ☐ Myasthenia gravis

Please list any autoimmune or connective tissue disorders:

☐ Cancer ☐ Radiation to head or neck

☐ Autism ☐ Psychiatric Problems ☐ Ilicit drugs

Please list any genetic syndromes or behavioral considerations:

Other Disease / Condition / Problem not listed that you think Dr. Ausnehmer should be aware of?

○ * **I certify that I have read and understand the above. I will not hold Dr. Ausnehmer, or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form.**

Name of patient, parent, or guardian completing this form:*

Relationship to patient:*

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Acknowledgement of Receipt of Notice of Privacy Practices
For Office of Amber L. Ausnehmer DDS, LLC

Signature **Date**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me unter the Health Insurance Portability and Accountability Act (HIPAA). I understand by signing this notice of privacy practices that I authorize Amber L Ausnehmer DDS, or her designated staff, my consent to use and disclose my protected health information for the following reasons:
* Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
* Obtaining payment from third party payers (i.e. insurance carriers)
* The day-to-day healthcare operations

I have also been informed of, and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my right under HIPAA. I understand that Amber L. Ausnehmer DDS reserves the right to change the terms of this notice and that I may contact her office at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that Amber L Ausnehmer DDS is not required to agree with these restrictions. However, if Amber L Ausnehmer DDS does agreee, I am bound to comply with the restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Printed Patient Name

Relationship to Patient

Signature & Date

Signature **Date**

PERMISSION TO RELEASE INFORMATION

The following is to give your permission to release any personal dental information to a spouse, parent, family member, or friend whom you specify to receive such information.

I give my permission to release my or my dependent's personal dental information to:

Name/Relationship

May we leave automated appointment reminders on your home or mobile phone? ◯ Yes ◯ No