ELIZABETH PLAS, D.M.D

3964 Edwards Rd. · Cincinnati, OH 45209

513.351.3700

www.elizabethplasdmd.com

Gentle Dental Care for Beautiful Smiles

REGISTRATION FORM

All information will be held in strict confidence.

Patient's Name_____ Birthdate _____

Home Address _____

City_____ State_____ Zip _____

Home Phone (_____) _____ Mobile (_____) _____ Work (_____) _____

Email*_____ Social Security Number _____ - _____ - _____

*We will email you informed consent forms prior to appointments

Marital Status? ❑ Single ❑ Married ❑ Divorced

Emergency Contact_____ Relationship_____ Phone (_____) _____

Who may we thank for referring you to our office?_____

FINANCIAL INFORMATION:

Who is financially responsible for this account? ❑ Self ❑ Spouse ❑ Parent

Policy Holder's Social Security Number _____ - _____ - _____

*Needed to process the insurance claim

Is their address and phone number the same as that of this patient? ❑ Yes ❑ No

Pay balance at time of treatment (Initial at line) _____

INSURANCE:

Is the patient covered by dental insurance? ❑ None ❑ One policy ❑ Two policies

PRIMARY POLICY	SECONDARY POLICY
Insurance Company _____	Insurance Company _____
Policy Holder's Name _____	Policy Holder's Name _____
Employer _____	Employer _____
Member ID Number_____	Member ID Number_____
Group Number _____	Group Number _____
Social Security Number _____	Social Security Number _____
Date of Birth _____	Date of Birth _____

*** MISSED APPOINTMENT FEE APPLIED FOR CANCELLATIONS LESS THAN 24 HOURS IN ADVANCE ***

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MEDICAL HISTORY

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Patient's Name_____ Birthdate_____ Today's Date _____

Primary Care Physician_____ City_____ Physician's Phone (___) _____

LIST THE MEDICAL SPECIALISTS YOU HAVE SEEN:

Physician's Name	Specialty	Physician's Name	Specialty

DESCRIBE YOUR OVERALL HEALTH:

❑ Outstanding (better than most people my age) ❑ Good (I don't know of any medical problem)

❑ Fair (I have some health problems but they're under control) ❑ Guarded (I have some current health problems)

❑ Poor (I have some major health problems) ❑ Other

When was the last time you saw your physician? (Year)_____ What was the purpose?_____

Have you ever been hospitalized or had a serious illness? ❑ No ❑ Yes, describe _____

HABITS:

Cigarettes ❑ Never ❑ Quit. When?_____ ❑ Smoking. Amount? _____ Start Date _____

Cigars ❑ Never ❑ Quit. When?_____ ❑ Smoking. Amount? _____ Start Date _____

Pipe ❑ Never ❑ Quit. When?_____ ❑ I use. Amount? _____ Start Date _____

Smokeless ❑ Never ❑ Quit. When?_____ ❑ I use. Amount? _____ Start Date _____

I Quit ❑ Yes How many times?_____ ❑ No Started Again Start Date _____

What technique did you use? ❑ Abstain ❑ Nicotine Patches ❑ Nicotine Gum ❑ Hypnosis

Alcohol Consumption: ❑ Total abstinence ❑ Other, describe frequency & amount

Do you use any recreational drugs? ❑ No ❑ Yes

WOMEN:

Are you pregnant? ❑ No ❑ Yes Estimated due date_____ Are you nursing? ❑ No ❑ Yes

Are you taking oral contraceptives? ❑ No ❑ Yes Are you taking hormorne replacement? ❑ No ❑ Yes

Are you on a treatment for osteoporosis & taking a class of medications called BISPHOSPHONATES? ❑ No ❑ Yes

Which one:_____ *(some (BUT NOT ALL) common names: Actonel®, Boniva®, Fosamax®, Fosemax Plus D®, Skella® & Didron®)*

ALLERGIES:

❑ Check here if no known allergies

Are you allergic to any of the following? ❑ Metals ❑ NSAIDs (like Motrin) ❑ Latex ❑ Penicilllin

❑ Sulfa ❑ Antibiotics ❑ Codeine ❑ Local Anesthetic ❑ Aspirin ❑ Other

Name the specific medication and describe your reaction _____

See Other Side

Patient's Name _____

List any sugeries or major events

Year	Event

Medications INCLUDING over-the-counter & herbal supplements

Name of Medicine	Dosage	Purpose: Why are you taking it?

DENTAL HISTORY:

Date of last dental visit_____ Name of last dentist _____

I view my teeth in: ❑ Good Condition ❑ Fair Condition ❑ Poor Condition

I view dentistry: ❑ Positively ❑ With Anxiety ❑ Negatively

Experiences you would like to share (positive or negative) _____

_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS?

Y N HEART/VASCULAR

- ☐ ☐ Heart attack (M)
- ☐ ☐ Congenital heart defect
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Irregular heartbeat (missed beats)
- ☐ ☐ Heart murmur
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Angina/Chest pains
- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ Artificial heart valve(s)
- ☐ ☐ Pacemaker
- ☐ ☐ By-pass surgery
- ☐ ☐ Stent placement
- ☐ ☐ Congestive heart failure
- ☐ ☐ Swelling of ankles
- ☐ ☐ Shortness of breath
- ☐ ☐ Other heart disease

Y N BLOOD

- ☐ ☐ Anemia
- ☐ ☐ Sickle cell disease
- ☐ ☐ Hemophilia
- ☐ ☐ Bruise very easily
- ☐ ☐ Prolonged bleeding
- ☐ ☐ HIV/AIDS

Y N CANCER

- ☐ ☐ Tumor_____
- ☐ ☐ Radiation treatment
- ☐ ☐ Chemotherapy
- ☐ ☐ Organ removal

☐ ☐ **ORGAN TRANSPLANT**

Y N RESPIRATORY

- ☐ ☐ Tuberculosis
- ☐ ☐ Emphysema
- ☐ ☐ Asthma
- ☐ ☐ Persistent cough
- ☐ ☐ Coughing up blood/sputnum
- ☐ ☐ Difficulty breathing lying down
- ☐ ☐ Winded going up 1 flight stairs
- ☐ ☐ Lung cancer
- ☐ ☐ Other lung disease

Y N BONE

- ☐ ☐ Arthritis/Rheumatism
- ☐ ☐ Osteoporosis
- ☐ ☐ Gout
- ☐ ☐ Artificial joints or limbs

Y N URINARY

- ☐ ☐ Kidney disease
- ☐ ☐ Renal dialysis
- ☐ ☐ Very frequent urination
- ☐ ☐ Burning on urination
- ☐ ☐ Blood or Discharge in urine
- ☐ ☐ Venereal disease
- ☐ ☐ Genital herpes

Y N DIGESTIVE SYSTEM

- ☐ ☐ Hepatitis, Type_____
- ☐ ☐ Gastric reflux
- ☐ ☐ Ulcers
- ☐ ☐ Frequent diarrhea
- ☐ ☐ Crohn's disease or Colitis

Y N NERVOUS SYSTEM

- ☐ ☐ Stroke (CVA) or TIA
- ☐ ☐ Severe headaches/Migraines
- ☐ ☐ Fainting or Dizzy spells
- ☐ ☐ Convulsions or Epilepsy
- ☐ ☐ Numbness or Tingling

Y N ENDOCRINE

- ☐ ☐ Diabetes: ❑ Type I ❑ Type II
- ☐ ☐ Excessive thirst
- ☐ ☐ Thyroid disease
- ☐ ☐ Hypoglycemia

Y N MENTAL HEALTH

- ☐ ☐ Depression
- ☐ ☐ Anxiety
- ☐ ☐ Panic attacks
- ☐ ☐ Psychiatric treatment
- ☐ ☐ Bipolar (manic-depressive)
- ☐ ☐ Addiction disorder
- ☐ ☐ Other

Y N HEAD/NECK/EYES

- ☐ ☐ Glaucoma
- ☐ ☐ Masular Degeneration
- ☐ ☐ Loss of hearing
- ☐ ☐ Tonsilitis
- ☐ ☐ Sinus problems

Patient Signature

_____

Doctor Signature

_____

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FINANCIAL AND OFFICE POLICY

Thank you for choosing Elizabeth Plas, D.M.D. as your dentist. We are committed to your treatment being successful and we appreciate your trust in us. Please understand that payment of your bill is considered part of your treatment. We find communication with our patients regarding our policies assists us in providing the best service possible. The following is a statement of our Financial Policy which we require you to read and agree to prior to your treatment.

- We are happy to file your insurance claims for you. In order to work with your insurance company, we must have complete and current information, a copy of your insurance card and your signature on file. If you have secondary insurance, you must present information at the time of registration. You must inform the office of all insurance changes and authorization requirements. You will be responsible for any charges that are denied by your insurance company which results from not providing the office with complete and current information. Due to timely filing limitations the office can not resubmit additional insurance policies if that information is not given at the time of service.
- Please understand there may be charges for Dental Services which your insurance considers non-covered and may be excluded from your policy. You are responsible for these fees and you authorize The Office of Dr. Elizabeth Plas to bill you for any appropriate services. This in accordance with your insurance company contract.
- All co-pays, co-insurance, deductibles and account balances are due at the time of service. We accept cash, check, MasterCard or Visa.
- Patients who are self-pay or have no insurance are required to pay the balance in full at the time of service.
- The patient is financially responsible for any additional charge for posterior composites (white fillings). Reimbursement may be lower for white fillings and the remaining amount is the patient's portion owed. Any amount not paid within 30 days is subject to a $15.00 billing charge.
- Missed appointments and/or canceling without 24 hours notice will be subject to a $50.00 office charge. This charge cannot be billed to your insurance company.
- Returned checks are subject to a $30.00 fee.
- Past due accounts are subject to collection proceedings. All fees including, but not limited to delinquent fees, and court fees will become your responsibility in addition to the balance due in this office.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE FINANCIAL POLICY

_____ _____

SIGNATURE (Patient or Person Financially Responsible) **DATE**

EMAIL AND TEXT MESSAGING CONSENT

Please initial to indicate that you agree to allow us to contact you through email and/or text message. _____

_____ _____

Email Mobile

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize Elizabeth Plas DMD to release the health information identifying me under the following terms and conditions:

1. Dental, medical and insurance informationspecifically relating to care of the teeth, periodontium, and oropharyngeal region.
2. Information may be released to dental specialists, general dentist, insurance companies and/ or insurance policy holders.
3. The purpose for the release is to facilitate dental care and insurance claim processing.
4. The release does not expire as long as the patients chart is held by the dental practice in accordance with the Ohio Dental Practice Act. Expiration will occur after patient care is discontinued.

It is your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. If you choose not to sign this form, dental insurance claim forms will be submitted by the patient and the patient will be responsible for the balance of treatment at the time of service.

If you sign this authorization you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked.

When your health information is disclosed as provided in this authorization, the recipient have no legal duty to protect confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

_____ _____

PATIENT SIGNATURE **DATE**

If you are signing as a personal representative of the patient, describe your relationship to the patient.

_____ _____

PRINT NAME **RELATIONSHIP TO PATIENT**

_____ _____

SIGNATURE **DATE**

Dr. Elizabeth Plas

NOTICE OF PRIVACY PRACTICES

I acknowledge that I read and understand Dr. Elizabeth Plas' Notice of Privacy Practices.

Signature: