Guest Form

Jon M Van Slate, DDS,FAGD,LVIF
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Patient Information

Please check if patient is a minor/child ☐

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred name: _____

Address: _____ City: _____ State:_____ Zip: _____

Phone / Home: _____ Work: _____Cell:_____

Sex: ☐ Male ☐ Female Employer: _____ E-mail address: _____

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Birth Date: _____Soc Sec #: _____Drivers Lic: _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency: _____ Phone: _____

Insurance Policy

Do you have dental insurance coverage? ☐ Yes ☐ No

Did you provide us with a copy of both sides of your insurance card prior to your appointment? ☐ Yes ☐ No

As a courtesy to you we file your insurance claim electronically and accept assignment of benefits. In the event your insurance company does not make payment in a reasonable time, or does not pay the estimated portion, you will be responsible for the balance. Our office is only a participating provider with Aetna PPO & Cigna Dental Savings Network.

Insurance Coverage

Policy Holder: _____ Employer:_____
Group#:_____ ID or SS#_____
DOB: _____ Relationship to Policy Holder: ___SP ___Self ___Dependent

Insurance Carrier: _____ Phone:_____

Payment Policy

Payment in full is expected at time of service. If you require extensive dental treatment, we have several options that may fit your needs, including CareCredit & Wells Fargo Health Advantage patient financing.

Please indicate how you will be paying today's services:

☐ Cash ☐ Check ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Authorization and Release

I understand that I am financially responsible for all charges whether or not paid by my dental and/or medical insurance carrier. I also understand that if I chose to go "out of network" with my dental insurance coverage and Dr. Van Slate is not a participating provider of my dental plan, I am responsible for all charges over what my PPO plan pays.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the office of Dr. Jon Van Slate to release any information including the 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 and /or health practitioners.

Signature of patient (or parent if minor) _____ Date: _____

Questionnaire

Jon Van Slate, DDS,FAGD,LVIF

To answer yes, please circle the words that apply to your experiences.

Have You Noticed Teeth sensitive to……?

Cold / Sweets / Pressure / Hot / Chewing / Other _____

Do you have ..... ?

Loose teeth / Bleeding gums / Bad Breath / Receding gums / Dry Mouth / Gum Disease

Do you have any of these jaw symptoms…..?

Jaw pain / Clicking / Popping / Locking open / Locking closed / Difficulty chewing

Tired Jaw Muscles / Accident involving your jaw / Clinching teeth / Grinding teeth / Uneven or unstable bite

Are you concerned about…..?

Yellow teeth / Crooked teeth / Chipped or Broken teeth / Spots or stained teeth

Gaps between teeth / Missing teeth / Difficulty flossing

Do you ever let these linger in your mouth….?

Hard Candy / Mints / Lemons / Pickle juice / Regular sodas / Diet Sodas / Ice Cream / Other

Do you ever ..... ?

Chew Ice or Hard Candy / Chew gum / Use your teeth as tools / Use tobacco / Floss between teeth Use toothpicks / Brush with hard or medium tooth brush / Scrub your teeth hard

In the past have you had……?

Braces / Gum Surgery / Root Canals / Tooth Whitening / Night Guard

Wisdom Teeth extracted / Other Teeth extracted / Oral Cancer / A Tooth Ache A

Broken Tooth / Deep Cleaning for Gum Disease

About your past dental care ….. _

Last cleaning: 3 – 4 months ago / 6 – 12 months ago / within 2 years / more than 2 years

Last x-rays: 3 – 4 months ago / 6 – 12 months ago / within 2 years / more than 2 years Last exam: 3 – 4 months ago / 6 – 12 months ago / within 2 years / more than 2 years

Frequency of dental visits: every 6 – 12 months / sporadically / seldom / never

How often do you brush? _____How often do you floss? _____

My main concern is _____

_____

Thank you for selecting our dental health care team! We will strive to provide you with the best possible dental care.

_____ _____ _____

Name Printed **Signature** **Date**

MEDICAL HISTORY-UPDATE

Patient Name: _____ DOB: _____

Height: _____ Weight:_____ BMI: _____ASA: _____

Office use only

Please supply your Dental Insurance Card with the update of this form

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 medication that you may be taking, could have an important inter relationship with the dentistry you will receive.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

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

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

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

Comments:

List additional supplements and vitamins:

Since your last visit, is there anything you would like to change about your smile?

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 _____

NOTICE OF PRIVACY PRACTICES for Jon M Van Slate, DDS, FAGD, LVIF, FIAPA

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (01/01/15), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to others outside of our office that are involved in your dental care. We will use and disclose your health information to other dentists and physicians to provide, coordinate, or manage your health care. For example, your health information may be provided to another dental specialist to whom you have been referred to ensure that the necessary information is available to diagnose or treat you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. For example, we may use a sign-in sheet at the reception desk where you will be asked to sign your name. We may also call your name in the waiting room when your doctor is ready to see you. We may send you reminder postcards or telephone you to remind you of an appointment. We may also send you a newsletter about our practice and the services we offer. You may contact our Privacy Officer to request that these materials **not** be sent to you.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in

effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0 for each page, $0 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Acknowledgement of Receipt
of
Notice of Privacy Practices

I _____have read and/or received a copy,
(Patients name – Printed)

Of the Notice of Privacy Practices for Jon M. Van Slate, DDS, FAGD, LVIF

_____ I give my permission to Dr. Van Slate and his staff that they may leave a
(initials)

message regarding confirmation of dental appointments on any phone number

that I have provided.

_____
(Patient Signature here)

Staff Will Fill Out This Section If Patient's Signature is Not Obtained

Our office made a good faith effort to obtain Acknowledgement of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reasons:

____ Patient refused to sign

____ Emergency situation kept us from obtaining the patient's signature.

____ Language barriers kept us from obtaining the patient's signature.

____ Other _____

Appointment Policy

Your appointment time is reserved just for you. Our goal is to provide you with excellent, personalized, dental care. We strive to exceed your expectations. Excellence does not just happen, it is planned.

Your appointment is chosen so we can give you priority attention, and the time necessary for performing the detailed procedures with excellence. Your cooperation enables us to do this by:

- Choose your appointment time thoughtfully to avoid conflicts of your time and make your appointment a priority.
- If you have special needs regarding the selection of your appointment times please let us know so we can assist you.
- Be on time to your appointment. Depending on the procedures planned, arriving late may necessitate rescheduling the appointment or modifying the treatment that can be performed in the remaining time.
- Call us well in advance if it becomes necessary to change your appointment. Most of our patients give us at least one week's notice.
    - We are sympathetic to an occasional emergency, as they are unplanned; however same day cancellations or failing to come to your appointment is considered a broken appointment. A broken appointment is a loss to all concerned.

    o Your treatment gets delayed, as our next opening may be many weeks later.

    o Another patient who would like to be seen sooner isn't given enough notice.

    o The practice loses time and revenue

    o Our preparation for your appointment is wasted.

- We have a strict cancellation policy in force and require 24 hour notice of all cancelled dental appointments. If you miss your reserved dental appointment and have not given our office sufficient notification, you will be charged $75.00 for your missed appointment.

A pattern of broken appointments may lead to dismissal from the practice.

Patient Signature:____________________________________ Date:_______________________