Aparna Sadineni, DDS, MAGD, FICOI

Restoring Confidence, One Smile At A Time

Welcome

DUBLIN METRO DENTAL GROUP
Cosmetic, General & Implant Dentistry

420 Metro Place South, Suite: B
Dublin, Ohio 43017
: smile@dublinmetrodental.com

Office: (614) 766-5600, Fax: (614) 766-2600
Mon – Fri: 8:00 A.M – 6:00 P.M, Sat: 8:00 A.M – 4:00 P.M
: www.DublinMetroDental.com

Thank you for selecting our dental healthcare team! To help us meet all your dental health care needs, please complete the following confidential information. If you have any questions or need assistance, please ask us we will be happy to help.

Date:_____

Patient Information

Patient Name:_____ _____ _____Prefers to be called by:_____
Last First M.I.

☑ Male ☐ Female Age _____ ☑ Married ☐ Single ☐ Child ☐ Other_____

Birth Date:_____ Social Security #:_____ Drivers License #:_____

Address: _____ _____ _____ _____
Street City State Zip Code

Email:_____
Required to confirm your appointment

Cell Phone: (_____)_____ (Home): (_____)_____ Work: (_____)_____
Required to discuss your dental health

Responsible Party Information

Responsible Party Name :_____ _____ _____Relationship to Patient:_____
Last First M.I.

☐ Male ☐ Female Age _____ ☐ Married ☐ Single ☐ Other_____

Birth Date:_____ Social Security #:_____ Drivers License #:_____

Address: _____ _____ _____ _____
Street City State Zip Code

Email:_____

Cell Phone: (_____)_____ (Home): (_____)_____ Work: (_____)_____

Personal and Referral Information

Whom may we thank for referring you to our practice? ☑ Another patient, friend ☐ Another patient, relative
☐ Another Dental Office ☐ Work ☐ Internet ☐ Other_____

Name of the person referring you to our practice:_____

Person to contact for emergency:

Name:_____Cell Phone: (_____)_____

Address:_____ _____ _____ _____
Street City State Zip

Employment Information

The following information is for: ☑ The Patient ☐ The Responsible Party(Relationship to Patient)_____

Employer Name:_____Phone:_____ Occupation:_____

Address: _____ _____ _____ _____
Street City State Zip Code

Insurance Information

Primary Insurance:

Patient's relationship to Insured : ☑ Self ☐ Spouse ☐ Child ☐ Other_____

Name of the Insured : _____ _____ _____ Is the Insured a patient? ☑ Yes ☐ No

Last First M.I.

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

Insurance Provider Phone No.: _____ Insured's Employer Name : _____

Insurance Provider Name and Address : _____

Secondary Insurance :

Patient's relationship to Insured : ☑ Self ☐ Spouse ☐ Child ☐ Other_____

Name of the Insured : _____ _____ _____ Is the Insured a patient? ☑ Yes ☐ No

Last First M.I.

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

Insurance Provider Phone No.: _____ Insured's Employer Name : _____

Insurance Provider Name and Address : _____

Consent for Services

I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that the use of such medications embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless prior arrangements are made. A service charge of, 1½% per month (18% APR) on the unpaid balance will be charged on all accounts exceeding 60 days without fully satisfied prior financial arrangements.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I also understand that a check of my credit history may be made.

I have read the above conditions of treatment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

(Signature of patient, parent or responsible party)

Aparna Sadineni, DDS, MAGD, FICOI
Restoring Confidence, One Smile At A Time

MEDICAL HISTORY

DUBLIN METRO DENTAL GROUP
Cosmetic, General & Implant Dentistry

420 Metro Place South, Suite: B
Dublin, Ohio 43017
: smile@dublinmetrodental.com

Office: (614) 766-5600, Fax: (614) 766-2600
Mon – Fri: 8:00 A.M – 6:00 P.M, Sat: 8:00 A.M – 4:00 P.M
: www.DublinMetroDental.com

Patient Information

Patient Name: _____ _____ _____ _____ Date: _____
Last First MI (Preferred Name)

Have your ever had any of the following? Please check those that apply:

- ☐ AIDS or HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Artificial Heart Valve
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ LiverDisease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Mitral Valve Prolapse
- ☐ Nursing
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Herpes
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Latex sensitivity
- ☐ Radiation
- ☐ Chemotherapy
- ☐ OTHER: _____

- Have you been admitted to a hospital or for emergency care during the past two years? ☐ Yes ☐ No
- If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
- If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
- If yes, please explain: _____

Current Medications (Both Prescription and Over the Counter):

Adverse reactions to medications in the past:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor before the next appointment.

_____ Date: _____
Signature of patient, parent or guardian

Office Use Only
History Review:

Dentist's Signature: _____ Date: _____

DENTAL HISTORY

DUBLIN METRO DENTAL GROUP
Cosmetic, General & Implant Dentistry

Welcome!
All the information you share with us is confidential.

Patient's Name: _____ _____ _____ _____ Date: _____
Last First MI (Preferred Name.)

A. Reason for Your Visit:
Do you have any other dental problems now? If yes, please describe: _____

B. Your Dental History:
Date of your last dental treatment: _____ Last cleaning: _____ Last full mouth x/rays: _____
Previous Dentist's Name: _____
Address: _____ State _____ Zip _____
Telephone: (_____) _____
How often have you had dental examination in the past? _____

C. Your Gums:

Do your gums bleed?	☑ No	☐ Yes	How often? _____
Do you have any bad odors or tastes?	☑ No	☐ Yes	Where? _____
Have you had gum treatment?	☑ No	☐ Yes	What type? _____
Have your parents had gum disease?	☑ No	☐ Yes	Which parent? _____
Have your parents experienced tooth loss?	☑ No	☐ Yes	Which parent? _____
Do you smoke or chew tobacco?	☑ No	☐ Yes	Which one? _____

D. Your Teeth:

Are you sensitive to hot or cold?	☑ No	☐ Yes	Where? _____
Are you sensitive to sweets?	☑ No	☐ Yes	Where? _____
Are your teeth sensitive to biting/chewing?	☑ No	☐ Yes	Where? _____
Does food get caught between your teeth?	☑ No	☐ Yes	Where? _____
Have you had oral surgery or extractions?	☑ No	☐ Yes	What type? _____

E. Your Bite:

Do you grind your teeth while you sleep?	☑ No	☐ Yes	Comments? _____
Have you had a clicking or popping jaw?	☑ No	☐ Yes	When? _____
Have you had pain in ear, joint, or face?	☑ No	☐ Yes	When? _____
Do you have aches in neck, and shoulder?	☑ No	☐ Yes	Where? _____
Do you have sore or tired jaws?	☑ No	☐ Yes	How often? _____
Do you get frequent headaches?	☑ No	☐ Yes	How often? _____
Have you had braces before?	☑ No	☐ Yes	When? _____
Have you had head or neck trauma before?	☑ No	☐ Yes	When? _____
Have you had night guards or bite guards?	☑ No	☐ Yes	What kind? _____

F: Your Appearance:
Are you satisfied with the appearance of your teeth? If not, please describe?
_____

Additional Comments: Is there anything else about having dental treatment that you want us to know?

G. Other:
Have you had an upsetting dental experience or complications following dental treatment in the past? If yes, please describe?

420 Metro Place South, Suite: B
Dublin, Ohio 43017
: smile@dublinmetrodental.com
Office: (614) 766-5600, Fax: (614) 766-2600
Mon – Fri: 8:00 A.M – 6:00 P.M, Sat: 8:00 A.M – 4:00 P.M
: www.DublinMetroDental.com

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 10/15/2008, 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 a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

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.

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 can not 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.

Photography Release: I authorize doctor and her staff to take photographs, slides, and videos of my face, jaws, and teeth.

I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising including website publication, newspapers, magazines, phone books, videotapes, DVDs, television, professional dental magazines and publications.

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I don't expect compensation, financial or otherwise, for the use of these photographs, slides and videos.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized 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.

Change of Ownership: In the event that this practice is sold or merged with organization, you health information/record will become the property of the new owner.

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 $0.30 for each page, $ 18.00 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 October 15, 2008. 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.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name (print)

Signature of Patient, Parent or Guardian

Date

Authorized Facility Signature

Date

Financial Policy

DUBLIN METRO DENTAL GROUP
Cosmetic, General & Implant Dentistry

420 Metro Place South, Suite: B
Dublin, Ohio 43017
: smile@dublinmetrodental.com

Office: (614) 766-5600, Fax: (614) 766-2600
Mon – Fri: 8:00 A.M – 6:00 P.M, Sat: 8:00 A.M – 4:00 P.M
: www.DublinMetroDental.com

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

Regarding Payment

We accept the following forms of payment: Cash, Visa and MasterCard.
Payment for services is due at the time services are rendered unless prior arrangements have been made with the financial coordinator. We offer a 5% accounting courtesy for all treatment plans of $2000.00 or greater that are paid in full prior to the first scheduled appointment of dental service. Our office also works with CareCredit to assist you with your payments. For qualified applicants, interest-free payments can be spread over a 3, 6 or 12 month period. Finance company approval must be obtained prior to starting your treatment.

If dentures, partial dentures, veneers, crown, bridge, six month smiles and Invisalign Orthodontics cases are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. Appointment time is reserved especially for you and 48-hour notice is required for any cancellation or rescheduled appointment to avoid a $50.00 cancellation fee.

Regarding Insurance

Your dental insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance companies arbitrary determination of usual and customary rates.

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be back dated. Most benefits will be verified before your insurance company can be billed. All insurance co-pays and deductibles must be paid at the time of service.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Patient/Responsible Party Signature:_____ Date:_____

Patient/Responsible Party Name:_____ Date:_____