



# WELCOME



We are pleased to welcome you to be a part of the Dorothy Lane Dental family! Please Take a few minutes to fill out this form as completely as you can. If you have any questions our staff would be more than happy to help you. We look forward to working with you to maintain your dental health!

## Patient Information

**Name:** \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Last Name First Name Middle Initial

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Separated  Divorced  Widowed  
Responsible Party for Account \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Last Name First Name Middle Initial  
Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_  
Notify In case of emergency \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

## Primary Insurance Information

Policy Holder Name \_\_\_\_\_  
Last Name First Name Middle Initial

Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Insurance Company \_\_\_\_\_  
Insurance Phone \_\_\_\_\_ Group# \_\_\_\_\_ ID # \_\_\_\_\_

## Secondary Insurance Information

Is patient covered by additional insurance?  Yes  No

Policy Holder Name \_\_\_\_\_  
Last Name First Name Middle Initial

Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Insurance Company \_\_\_\_\_  
Insurance Phone \_\_\_\_\_ Group# \_\_\_\_\_ ID # \_\_\_\_\_

## Medical History

Are you currently under a physician's care now?  Yes  No    If yes why? \_\_\_\_\_

Have you ever been hospitalized or had a major surgery?  Yes  No

If yes why/what for? \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No    If yes what? \_\_\_\_\_

Taking any medications?  Yes  No    If yes what? \_\_\_\_\_

Are you on a special diet?  Yes  No

Do you use tobacco?  Yes  No

Do you use a controlled substance?  Yes  No

If yes what? \_\_\_\_\_

**Women Only:** Are you...

Pregnant/Trying to get pregnant

Nursing?

Taking oral contraceptives?

Do you have any known allergies?  Yes  No    If yes what? \_\_\_\_\_

Please check if you have, or have you had, any of the following?

AIDS/HIV Positive

Cortisone Medication

Hemophilia

Radiation Treatments

Alzheimer's disease

Diabetes

Hepatitis A

Recent Weight Loss

Anaphylaxis

Drug Addiction

Hepatitis B or C

Renal Dialysis

Anemia

Easily Winded

Herpes

Rheumatic Fever

Angina

Emphysema

High Blood Pressure

Rheumatism

Arthritis/Gout

Epilepsy / Seizures

High Cholesterol

Scarlet Fever

Artificial Heart Valve

Excessive Bleeding

Hives / Rash

Shingles

Artificial Joint

Excessive Thirst

Hypoglycemia

Sickle Cell Disease

Asthma

Fainting / Dizziness

Irregular Heartbeat

Sinus Trouble

Blood Disease

Frequent Cough

Kidney Problems

Spina Bifida

Blood Transfusion

Frequent Diarrhea

Leukemia

Stomach/Intestinal Disease

Breathing Problems

Frequent Headaches

Liver Disease

Stroke

Bruise Easily

Genital Herpes

Low Blood Pressure

Swelling of Limbs

Cancer

Glaucoma

Lung Disease

Thyroid Disease

Chemotherapy

Hay Fever

Mitral Valve Prolapse

Tonsillitis

Chest Pains

Heart Attack/Failure

Osteoporosis

Tuberculosis

Cold Sores/Fever Blisters

Heart Murmur

Pain in Jaw Joints

Tumors or Growths

Congenital Heart Disorder

Heart Pacemaker

Parathyroid Disease

Ulcers

Convulsions

Heart Trouble/Disease

Psychiatric Care

Venereal Disease

MRSA

Mono

Back Problems

COPD

Other? \_\_\_\_\_

## Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there are any changes to my medical history I will inform the dentist.

I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Dorothy Lane Dental

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## HIPAA Notice of Privacy Practices

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

We are required by law to maintain the privacy of protected health information (PHI), to provide individuals with the notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This Notice takes effect 8/15/2018, 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, and to make a new Notice provisions effective for all protected health information that maintain. When we make a significant change in our privacy practices, we will change this notice and post the new Notice clearly and prompt our practice location and will provide copies of the new Notice 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.

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### **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

We may use and disclose your health information for difference purposes, including treatment, payment and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

**Treatment.** We may use and disclose your health information for you treatment. For example, we may disclose your health information to a specialist treating you.

**Payment.** We may disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved in your care. Payment activities including billing, collections, claim management, and determinations of eligibility and coverage to obtain payment from you, an insurance company or another third party. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations.** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs and licensing activities.

**Individuals Involved in You Care or Payment for You Care.** We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment of your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat the patient representative the same way we would treat you with respect to your health information.

**Disaster Relief.** We may disclose your health information to assist in disaster relief efforts.

**Required by Law.** We may disclose your health information when we are required to do so by law.

**Public Health Activities.** We may disclose your health information for public health activities, including disclosure to:

- Prevent or control disease, injury or disability.
- Report child abuse or neglect.
- Report reactions to medications or problems with products or devices.
- Notify a person of recall, repair, or replacement of products of devices.
- Notify a person who may have been exposed to a disease or condition.
- Notify the appropriate government authority if we believe a patient has been victim of abuse, neglect or domestic violence.

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

**Secretary of HHS.** We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Workers Compensation.** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

**Law Enforcement.** We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as a required by law, or in response to subpoena or court order.

**Health Oversight Activities.** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs and compliance with civil rights laws.

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**Judicial and Administrative Proceedings.** If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a court or administrative order. We may disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute only if efforts have been made, either by the requesting party to us, to tell you about the request or obtain an order protecting the information requested.

**Research.** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

**Coroners, Medical Examiners and Funeral Directors.**

We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may disclose your PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

**Fundraising.** We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving communications.

**OTHER USES AND DISCLOSURES OF PHI**

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

**YOUR HEALTH INFORMATION RIGHTS**

**Access.** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically you have the right to an electronic copy. We will use this form and format your request if readily producible.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Disclosure Accounting.** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information you must submit your request in writing to the privacy Official. 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 the additional requests.

**Right to Request a Restriction.** You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you would like to limit, (2) whether you want to limit or use, disclosure or both and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person your behalf (other than the health plan), has paid our practice in full.**

**Alternative Communication.** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

**Amendment.** You have the right to request that we amend your PHI. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

**Right to Notification of a Breach.** You will receive notifications of breaches of your unsecured PHI as required by law.

**Electronic Notice.** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our website [www.dorothylanedental.com](http://www.dorothylanedental.com) or by e-mail.

**Questions and Complaints.** If you want more information or have any questions or concerns, please contact us.

**If you are concerned that we may have violated your privacy rights, or if 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 an alternative location, you may complain to us using the information listed below. 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 PHI. We will not retaliate in any way if you choose to file a complaint with us or to the U.S. Department of Health and Human Services.**

**Our Privacy Official: Autumn E.**

**Telephone: (937) 298-4221**

**Fax: (937) 395-3665**

**Address: 3020 S. Dixie Dr. Kettering, OH 45409**

**E-Mail: [billing@dorothylanedental.com](mailto:billing@dorothylanedental.com)**

# Dorothy Lane Dental

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## Dental Insurance Agreement

At Dorothy Lane Dental we pride ourselves in offering the best quality of care to our patients, and as a courtesy we go over pre-treatment estimates as well as submitting claims on our patients' behalf. **Please note that insurance companies have ever changing regulations, benefits, deductibles, downgrade charges and allowable charges that unfortunately only allows our office to estimate a patients' co-payment.** Please also keep in mind that the dental insurance contract is between the insurance company and the patient, and that after our office receives payments from the insurance company for treatments rendered anything remaining is the patients' responsibility. **Co-Payments must be paid at the time of service and if you have an account balance, we will expect that you come prepared to pay that balance in full along with your co-payment. There is a \$35.00 processing fee for any and all returned or bounced checks and you will no longer be able to use this payment method in the future.** The treatment recommended by Dr. Loganathan is never based on what your insurance company will pay but the treatment we feel is in your best interest. Please take the time to thoroughly review your dental contract so that our office can best serve you. If you do have any questions or concerns in regards to your insurance company our front office staff is always available to help clarify to the best of our abilities your services, billing and insurance questions. **Please notify our office PRIOR to any dental appointments if there are any dental insurance changes for yourself and /or family.** Thank you!

Patient Name:

Date:

Patient/Parent/Guardian Signature:

## Office Policy / Patient Appointment Agreement

At Dorothy Lane Dental we pride ourselves in offering the best quality of care to our patients, and as a courtesy we offer several ways in which to confirm patient appointments. **As a courtesy to our office we do ask that you confirm every appointment so that we can best serve our patients' needs. If for any reason you do need to cancel / reschedule an appointment our office does require two business days' notice to do so or you could be subject to a \$25.00 charge per hour of scheduled appointment or possible dismissal from our practice.** If at any time you need to cancel or reschedule your appointment and our office is closed, or our office staff is assisting with other patients and you are unable to get a hold of us you can always leave a voice message on our answering service which is checked several times throughout the day. Please note that if more than one family member is scheduled per day and one or more of those family members short notice cancel or no show to the appointment that family will no longer be able to schedule appointments together on the same date. If you have any questions and / or concerns regarding our office policy our front office staff is always available to clarify any questions you may have. Thank you!

Patient Name:

Date:

Patient/Parent/Guardian Signature: