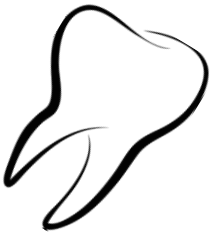
WELCOME



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 _____
Last Name First Name Middle Initial
Relationship to patient _____ 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

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.

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.

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 evocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action I 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 accessibly 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 review 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 you 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 you 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 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 locations, 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

Dorothy Lane Dental

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:

Acknowledgment of HIPAA Privacy Policy

At Dorothy Lane Dental we pride ourselves in respecting and following our patients' HIPAA privacy rights which states that unless directed to by our patient we are unable to give any personal information including but not limited to treatment inquires, financial inquires, changing/cancelling and / or scheduling appointments as well as giving out any personal account information to anyone other than the patient unless we do need to refer to a specialist. If there is anyone that you would like to have access to your account, financial status and / or treatment with our office please make notation of this person as well as their relationship to the patient below. If you would like a copy of the HIPAA Privacy Act or a copy of this signed form please let one of our office staff know so that we can provide them for you.

I, , was offered / or have received a copy of Dorothy Lane Dentals Notice of Privacy Practices and thoroughly understand its' meaning.

I give , access to make/cancel or schedule appointments on my behalf when I am unable to do so, as well as take messages from Dorothy Lane Dental.

Relationship to Patient:

I give , access to my treatment plans as well as my financial standings and account balances with Dorothy Lane Dental.

Relationship to Patient:

Date:

Patient/Parent/Guardian Signature:

For Office Use Only

___ Individual Refused to Sign

___ Communication barriers prohibited obtaining acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Patient/Parent or Guardian declined getting a copy of the Notice of Privacy Practices _____

___ Other (Please Specify) _____

Communication Agreement

Our practice offers several forms of patient communications and would like to know which option would be best suited for your schedule. Our patient communications can be used for confirming appointments, following up in regards to account balances, sales/promotions, emergency situations where appointments may need to be cancelled by the office, last minute appointment openings, and reminders. You may opt out to any of these communications either electronically or by contacting our office at (937) 298-4221 and you are responsible for any updates of telephone number(s) and / or your email address. We do ask that you contact our office to confirm any / all appointments. If for some reason you do need to cancel or reschedule you will need to call our office at (937) 298-4221 due to our text and automated systems not having that capability, and please keep in mind we do ask for two business days' notice or you could be subject to a fee of $35.00.

Patient Name: _____ Date of Birth: _____

I agree that Dorothy Lane Dental may communicate with me through:

- □ Text Message Communications
  - o Please Provide Cell Phone Number (_____)_____
- □ E-Mail Communications
  - o Please provide email (Please print clearly)
    _____@_____
- □ Telephone Communications
  - o (_____)_____ Home / Cell
  - o (_____)_____ Home / Cell
- □ Automated Communications (CONFIRMATIONS ONLY)
  - o (_____)_____ Home / Cell
- □ Our office doesn't need to call/text/email to CONFRIM appointments.

I am aware that with certain forms of communication there is some level of risk that third parties might be able to read text messages and encrypted e-mails.

Patient Signature: _____ Date: _____

Patient Screening Form

ADA

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.