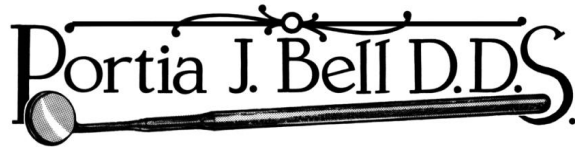


***Portia J. Bell, DDS, Inc.***

2710 Crossroads Plaza Drive

# New Patient Enrollment Forms



**Welcome To Portia J. Bell, DDS, Inc. - Tell Us About Yourself**

Name(Last)\_\_\_\_\_ (First)\_\_\_\_\_ (MI)\_\_\_\_ (Title)\_\_\_\_\_

D.O.B \_\_\_\_\_ SS# \_\_\_\_\_

Marital Status \_\_ Single \_\_ Married \_\_ Divorced \_\_ Widowed \_\_ Separated \_\_ Domestic Partner \_\_

Preferred Name \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Other family members who will be patients in this office:

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

Who is financially responsible for this account? \_\_\_\_\_

Nearest relative not living with you \_\_\_\_\_ Phone \_\_\_\_\_

Will we be filing dental insurance for you? \_\_\_\_\_ If yes, please provide the following information:

Name of Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Subscriber Name \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_

Is there anything we can do to make your visit here more comfortable or pleasant? \_\_\_\_\_

Who may we thank for referring you to our practice? \_\_\_\_\_

## **Dental History**

What is the reason for your visit today? Evaluation/Cleaning \_\_\_\_\_  
(Please check all that apply) Toothache/Consultation \_\_\_\_\_  
Broken Tooth Consultation \_\_\_\_\_  
Gum Problem \_\_\_\_\_  
Cosmetic Consultation/Evaluation \_\_\_\_\_

Your current dental health is: \_\_\_ Good \_\_\_ Fair \_\_\_ Poor

Are you currently in pain? \_\_\_ Yes \_\_\_ No

Have you ever had gum treatment? \_\_\_ Yes \_\_\_ No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) \_\_\_ Yes \_\_\_ No

Do you like your smile? \_\_\_ Yes \_\_\_ No

Is there anything you would like to change about your smile? \_\_\_ Yes \_\_\_ No

Are you happy with the color of your teeth? \_\_\_ Yes \_\_\_ No

Do your gums bleed? \_\_\_ Yes \_\_\_ No

How many times a day do you: floss/ week? \_\_\_\_\_ brush/day? \_\_\_\_\_

Are your teeth sensitive to heat, cold, or anything else? \_\_\_ Yes \_\_\_ No

Have you lost any teeth? \_\_\_ Yes \_\_\_ No

Have you ever had an unfavorable dental experience? \_\_\_ Yes \_\_\_ No

Would you like us to prescribe a calming pill for you prior to treatment appointments? \_\_\_ Yes \_\_\_ No

Have you ever had a serious/ difficult problem with any previous dental work? \_\_\_ Yes \_\_\_ No

When was your last cleaning? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_

Have you dental x-rays with the last 12 months? \_\_\_\_\_

Why did you leave your previous dentist? \_\_\_\_\_

Here at **PORTIA J. BELL DDS, INC.** we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Tooth Whitening	Veneers/ Lumineers	Bonding	Cancer Screening
Smile Makeover	Sealants	Crown and Bridge	Implant Crowns
Partials/ Dentures	Night/ Sport Guards		

## **Medical History**

Have you had hip/knee replacement surgery or any heart surgery in the last two years? \_\_\_\_\_  
If you answered yes, please call your surgeon to inquire if you will need an antibiotic before your dental treatment.

### **Are you allergic to any of the following?**

- | <b>Yes</b>               | <b>No</b>                                |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Penicillin      |
| <input type="checkbox"/> | <input type="checkbox"/> Nuts or Avocado |
| <input type="checkbox"/> | <input type="checkbox"/> Codeine         |
| <input type="checkbox"/> | <input type="checkbox"/> Aspirin         |
| <input type="checkbox"/> | <input type="checkbox"/> Sulfa Drugs     |
| <input type="checkbox"/> | <input type="checkbox"/> Latex           |
| <input type="checkbox"/> | <input type="checkbox"/> Amoxicillin     |

### **Do you have or have you ever had any of the following?**

- | <b>Yes</b>               | <b>No</b>  | <b>Yes</b>               | <b>No</b>   |
|--------------------------|--|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatic Fever                     | <input type="checkbox"/> | <input type="checkbox"/> Diabetes                       |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Condition                     | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis A, B, or C           |
| <input type="checkbox"/> | <input type="checkbox"/> Any Surgery                         | <input type="checkbox"/> | <input type="checkbox"/> Tuberculosis                   |
| <input type="checkbox"/> | <input type="checkbox"/> Kidney problems                     | <input type="checkbox"/> | <input type="checkbox"/> Anemia                         |
| <input type="checkbox"/> | <input type="checkbox"/> Stroke                              | <input type="checkbox"/> | <input type="checkbox"/> Bleeding problems              |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis                           | <input type="checkbox"/> | <input type="checkbox"/> Asthma                         |
| <input type="checkbox"/> | <input type="checkbox"/> High blood pressure                 | <input type="checkbox"/> | <input type="checkbox"/> Orthodontic treatment (braces) |
| <input type="checkbox"/> | <input type="checkbox"/> Sinus problems/allergies            | <input type="checkbox"/> | <input type="checkbox"/> Eye Surgery                    |
| <input type="checkbox"/> | <input type="checkbox"/> Pain in jaw joint/ear/side of face  | <input type="checkbox"/> | <input type="checkbox"/> Digestive system disorders     |
| <input type="checkbox"/> | <input type="checkbox"/> Difficulty opening or closing mouth | <input type="checkbox"/> | <input type="checkbox"/> HIV / Aids                     |
| <input type="checkbox"/> | <input type="checkbox"/> Women, are you pregnant?            |                          |   |
| <input type="checkbox"/> | <input type="checkbox"/> Tobacco use of any kind             |                          |   |

**If you have any condition or problem not mentioned that you feel we should be aware of, please note here:**

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Name of personal physician \_\_\_\_\_ Phone # \_\_\_\_\_  
Date of last visit: \_\_\_\_\_

Name of specialty physician \_\_\_\_\_ Phone # \_\_\_\_\_  
Date of last visit: \_\_\_\_\_

### **Current Medications:**

Name \_\_\_\_\_ Dosage \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_

If you need additional space please provide us with a list we may keep on file.....

"I understand that the information I have provided on this form is essential to determine my dental needs and to provide proper dental treatment. I understand that if any change in my health occurs, I am to inform this office at my next scheduled appointment so that my medical history can be updated. I understand each question and have answered each of them truthfully and to the best of my ability."

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Signature

Date



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### **Consent**

I authorize the staff and doctors at Portia J. Bell DDS to obtain x-rays, study models, and photographs, or any other diagnostic aids deemed appropriate to make a thorough analysis. I will be given the opportunity to discuss my treatment plan with the doctor, and financial arrangements will be agreed upon before commencing treatment.

### **Dental Insurance**

We are happy to file forms necessary to see that you receive any benefits available to you. We cannot guarantee any estimated coverage. As a courtesy to our patients, we will file your dental insurance claim forms, however, please be aware that we may not be a participating provider with your insurance company. As an out of network dental office, you may incur additional co-pay. Unless prior arrangements are made, you will be expected to pay the percentage of your responsibility as services are performed. Please keep in mind that we can only estimate your portion. If there is a difference after your insurance company has paid, it is your responsibility to pay the difference. Because the insurance policy is an agreement between you and the insurance company, we will not enter into a dispute with your insurance company over your claim. We will provide information to support the necessity for treatment, which may assist you in recovering your benefits.

We realize that every person's financial situation is different. For this reason we have worked very hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile.

### **Payment Options**

*Prepayment courtesy:* We are happy to offer a 5% pre-payment courtesy for treatment that exceeds \$100.00 and is paid in full prior to treatment.

*Monthly Payment plan:* For patients who desire a monthly payment plan, and for those whose treatment fee is in excess of \$200.00, we offer a range of monthly payment plans by either preauthorized checking or credit card withdrawals treatment will be scheduled once payment plan is completed.

*Extended Payment Plan:* A convenient line of credit can be arranged, on approval, for all your health needs. Minimum treatment fee is \$1000.00.

## **Financial Responsibility**

- Payments extending beyond 30 days from first billing will accrue interest at the rate of 1.5% per month of the unpaid balance. (18% annual rate)
- There is a 35.00 charge for all returned checks
- In the event of default, I promise to pay legal interest on indebtedness, collection costs, and/or related legal fees.

## **Our Appointment Policy**

In order to provide the best service, we see patients on an appointment basis. We consider an appointment like a contract of time reserved for treatment. We realize that our patient's time is valuable; therefore, we make every effort to keep waiting time to a minimum. We request the same courtesy from our patients. If you find it impossible to keep an appointment, please give our office 48 hours notice so that we can accommodate someone else in that time. We reserve the right to charge a \$35.00 fee for missed appointments cancelled at the last minute.

### **Please sign below indicating your acceptance of the following:**

I understand both the appointment policy and financial responsibilities of Portia J. Bell DDS, INC.

I understand your insurance guidelines and wish for Portia J. Bell DDS, INC. to accept the assignment of benefits from my insurance company.

I acknowledge that I have been provided with a copy of the HIPPA Notice of Privacy Practices. The effective date is April 14, 2003. I understand that my signature only represents my receipt of this notice.

I authorize Portia J. Bell DDS, INC. to use any photographs or radiographs of my completed treatment for the purposes of publication and/or teaching.

I understand Portia J. Bell, DDS, INC. submits insurance claims on my behalf as a courtesy. The contract of my dental coverage is between the insurance company and myself. I understand I am responsible for the payment of any fees incurred for the dental services.

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Please Print Full Name Legibly

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Signature

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Date

# **Portia J. Bell, DDS, Inc.**

2710 Crossroads Plaza Drive

## **NOTICE OF PRIVACY PRACTICES**

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED, 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 April 14, 2003, 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 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 judgement 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 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.

**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. You may also request access by sending us a letter to the address at the end of this Notice.)

**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.

**Restrictions:** 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.

Contact Officer: Portia J. Bell, D.D.S., INC

Telephone: (614) 471-1161

Fax: (614) 471-2586

E-Mail: [drbell@drportiabell.com](mailto:drbell@drportiabell.com)

Address: 2710 Crossroads Plaza Drive  
Columbus, Ohio 43219

**Portia J. Bell, DDS, Inc.**

2710 Crossroads Plaza Drive

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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\*You May Refuse To Sign This Acknowledgement

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

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Please Print Name

Signature

Date

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**For Office Use Only**

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We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)