TUTTLE CROSSING
dental group

Phillip Elmo, D.D.S., Inc.

Patient's Name _____ _____ / _____ / _____
First Last Initial Date of Birth

To our patients:
Although dentists primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care you will be receiving. Your answers are for our records only and will be considered confidential.

CIRCLE THE APPROPRIATE ANSWER

1. Are you in good / fair / poor health? (circle one)
2. Have you ever had a serious illness, operation, or been hospitalized in the last five years? ..... YES NO
3. Are you under a physician's care? ..... YES NO
   If YES, Physicians's name: _____
4. Are you taking any medication at present? ..... YES NO
   If YES, list under "COMMENTS"
5. Are you allergic to any medications? ..... YES NO
   If YES, list under "COMMENTS"
6. Have you ever been told that you have heart disease? ..... YES NO
7. Have you ever been told that you have a heart murmur, or a mitral valve prolapse? (circle one) ..... YES NO
8. Have you ever had rheumatic fever or bacterial endocarditis? (circle one) ..... YES NO
9. Do you have high or low blood pressure? ..... YES NO
10. Do you have inflammatory diseases, such as arthritis or rheumatism? (circle one) ..... YES NO
11. Have you ever had surgery, radiation treatment, or chemotherapy for a tumor, growth, or other condition? If YES, list under "COMMENTS" ..... YES NO
12. Do you have any artificial joints/prostheses? ..... YES NO
13. Do you have a heart pacemaker? ..... YES NO
14. Have you ever bled excessively following any dental procedure or after being cut or injured? ..... YES NO
15. Do you have any lung problems such as emphysema? ..... YES NO
16. Have you had any stomach or kidney problems? (circle one) ..... YES NO
17. Are you diabetic? ..... YES NO
18. Do you have asthma? ..... YES NO
19. Do you have latex (rubber) sensitivity? ..... YES NO
20. Do you have epilepsy or a seizure disorder? (circle one) ..... YES NO
21. Do you have AIDS or have you been told that you are HIV positive? YES NO
22. Have you had hepatitis? ..... YES NO
23. Do you have or have you had TB? ..... YES NO
24. Do you smoke? ..... YES NO
25. Have you been told you have glaucoma? ..... YES NO
26. Do you have or have you had venereal disease? ..... YES NO
27. Do you wear contact lenses? ..... YES NO
28. Do you faint easily or have you been told you have low blood sugar? (circle one) YES NO
29. Do you have any disease or problem not listed? ..... YES NO
    If so, please explain _____
    _____
30. Do you have any mental health problems and/or been treated for depression? ..... YES NO
31. Would you like to speak to the Doctor privately about any problem? ..... YES NO
32. Is there anything else we should know about your health that is not covered in this form? If yes, list under "COMMENTS" ..... YES NO

WOMEN:

33. Are you pregnant or is there a possibility that you may be pregnant? YES NO
34. Are you nursing? YES NO
35. Are you taking birth control pills? YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S SIGNATURE _____ **DATE** _____

DENTIST'S SIGNATURE _____ **DATE** _____

ANEST.		MED ALERT

MEDICAL HISTORY

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

TUTTLE CROSSING
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Phillip Elmo, D.D.S., Inc.

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 4/13/03, 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 changes in our privacy practices and the new terms of our Notice effective for all health information 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 and 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 the services we provide to you.

Healthcare Operations
We may use and disclose your health information in connection with our 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 authorization, you make 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 may use and disclose your health information to you, as described in the Patient Rights section of the Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with 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 judgement 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 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 reasonable 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.

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

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 can not 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 $__0.50__ for each page, $__15.00__ 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 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 alternative 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 must 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 using alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also 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 to 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 the U.S. Department of Health and Human Services.

Contract Officer: **Dr. Phillip Elmo D.D.S., Inc.**

Telephone: **(614) 798-0083** Fax: **(614) 764-9184**

E-mail: **N/A**

Address: **5155 Bradenton Ave, Ste #110 Dublin, OH 43017**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement

TUTTLE CROSSING
dental group

Phillip Elmo, D.D.S., Inc.

I, _____, have received a copy of our office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices. Our Notice of Privacy Practices 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)

_____

_____

_____

_____

TUTTLE CROSSING
dental group

Phillip Elmo, D.D.S., Inc.

Dear Patient,

We have prepared this letter to help you better understand the complexities of dental insurance; we realize how confusing it can be. To begin, we would like to highlight a misconception - dental insurance was not designed to pay for dental care. Most contacts have limits and/or various degrees of co-payment.

All levels of payments by insurance companies, including allowed fees, usual and customary (UCR), as governed by the premiums paid. They have nothing to do with the actual charges. Our fees are based on a combination of costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.

However, it should be understood, that the dental insurance contract is between the insurance company and the patient, whom bears the ultimate financial responsibility.

We hope this information has been helpful. Please take the time to review your contract thoroughly so we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services.

Signature _____

Date _____

TUTTLE CROSSING
dental group

Phillip Elmo, D.D.S., Inc.

Date _____ /_____ /_____

Patient _____

Date of Birth _____ /_____ /_____ SS# _____ – _____ – _____

Address _____ City _____ State _____ Zip _____

Home Ph (_____) _____ Cell Ph (_____) _____ Other _____

Employer _____ Position _____

Business Address _____

Business Ph (_____) _____ Ext. _____

Spouse's Name _____

Date of Birth _____ /_____ /_____ SS# _____ – _____ – _____

Address _____ City _____ State _____ Zip _____

Home Ph (_____) _____ Cell Ph (_____) _____ Other _____

Employer _____ Position _____

Business Address _____

Business Ph (_____) _____ Ext. _____

Primary Dental Insurance Company _____

Claims Mailing Address _____

_____

_____

Group # _____ Phone (_____) _____

Cardholder's Name _____

SS# _____ – _____ – _____ Date of Birth _____ /_____ /_____

Secondary Dental Insurance Company _____

Claims Mailing Address _____

_____

_____

Group # _____ Phone (_____) _____

Cardholder's Name _____

SS# _____ – _____ – _____ Date of Birth _____ /_____ /_____

If NO INSURANCE, person responsible for account _____

Who can we thank for referring you? _____

I authorize the release of any information regarding dental treatment. I understand that I am responsible for all fees incurred.
I authorize insurance payment to be paid directly to Tuttle Crossing Dental Group.

Signature _____ **Date** _____

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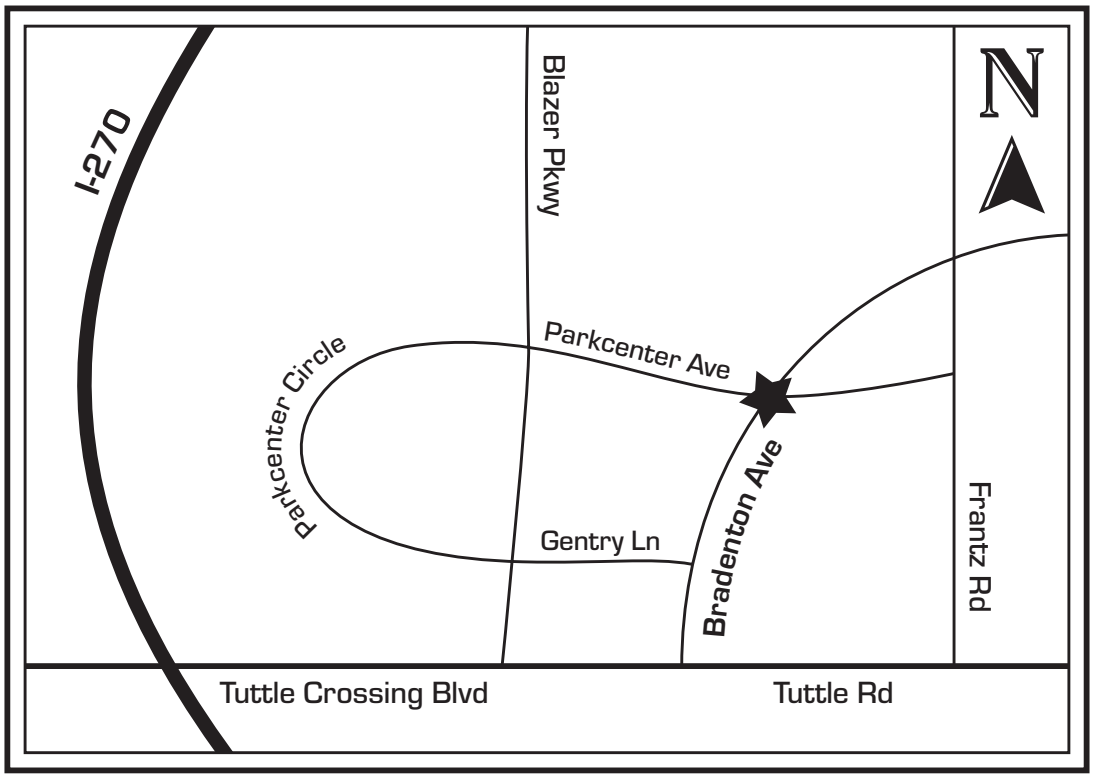
Phillip Elmo, D.D.S., Inc.



5155 Bradenton Avenue, Suite 110 | Dublin, OH | 43017
Telephone: (614) 798-0083 | Fax: (614) 764-9184

FOR MORE INFORMATION AND SPECIFIC DIRECTIONS PLEASE VISIT OUR WEBSITE
www.tcdentalgroup.com