MEDICAL/DENTAL HISTORY

Name of your Physician:____ **Date of Last Visit**:_____________

Please circle any of the following that you have or have had:

Heart Trouble	Cancer	Asthma
Rheumatic Fever	Radiation Treatment	Hives or Skin Rash
Mitral Valve Prolapse	Arthritis	Depression\Anxiety
Heart Murmur	Osteoporosis	Substance Abuse
Angina	Joint Replacement Surgery	Venereal Diseases
Stroke	Liver Disease-jaundice/hepatitis	Herpes Oral (cold sores)
High Blood Pressure	Kidney Disease	Herpes Genital
Diabetes	Thyroid Condition	HIV Positive
Fainting Spells/Seizures	Ulcers	AIDS
Clenching\Grinding TMJ Disorder	Sinus Trouble	Tuberculosis
Bleeding Disorder	Environmental Allergies	Major Surgery

Please list any medications you are allergic or have reacted adversely to:

Name	Reaction	Name	Reaction

Please name all current medications, dosage, & reason for taking them:

Name	Dose	Reason	Name	Dose	Reason

Do you smoke?__________
Women: Are you pregnant?_________
Do you have any other disease, condition, or problem not listed above?_____ **Please explain**________________________

Dental History

1. Have you had any trouble associated with previous dental treatment (dizziness, fainting or reaction to novocaine)? Yes No
2. Do you have any lumps or sores in your mouth now? Yes No
3. Are you Allergic to Latex? Yes No Reaction ______________________

To the best of my knowledge, the above information is correct and complete.

Patient's Signature ____________________ **Date** __________ **Reviewed** ________ **Date** ________

Patient's Signature ____________________ **Date** __________ **Reviewed** ________ **Date** ________

Microsurgical Endodontics

Registration

Patient name:____

Address:______________________ City: __________State: ___ Zip: ________

Phone# Home: ( ) - Work: ( ) - Cell: ( ) -

Preferred phone contact: (please circle) Home Work Cell

How would you like to be addressed by our staff: ______________________________

Social Security #: - - Date of birth: - -

Employer:______________________Occupation: ____________________

Address:______________________ City: __________State: ___ Zip: ________

Referring dentist:____

Complete only if information is not provided above

Person responsible for acct:___________________Relationship to Patient: ________

Address:______________________ City: __________State: ___ Zip: ________

Home phone: ( ) - Work phone: ( ) -

Do you have dental insurance through your employer? Yes __ No__

If yes, please provide the following information.

Name of Insurance Company:___________________ Ins Co. Phone: ( ) -

Address:______________________ City: __________State: ___ Zip: ________

Group #:________

Do you have any other dental insurance coverage? Yes __ No__

This coverage is through: __Spouse __Parent __Other

Their Name:______________________ Their Employer: ____________________

Their Date of Birth / / Social Security # - - Work Phone ( ) -

Their Insurance Company:______________________ Ins Co. Phone ( ) -

Ins. Co. Address:__________________ City:__________State:____Zip: ________

Group #:_______

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named dental entity and authorize release of any information relating to a claim. ______________________________ ____________

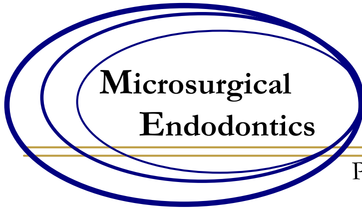
Signature of Insured Person Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Signature________________________________ Date__________________

Revised October 10, 2014



Robert A. Uhle D.D.S., M.S.
Matthew S. Niemiec D.D.S., M.S.

Practice Limited to Endodontics

SPECIALIST MEMBERS

Welcome to Our Office

Our Goal is to provide you with state of the art endodontic treatment in a comfortable and relaxing setting. Please feel free to bring up any questions about your treatment with our doctors or office staff.

We never want you to be surprised about the cost of treatment. Please verify the approximate cost of your treatment prior to being seen. You will be responsible for payment at the time of treatment. We accept Cash, Checks, Mastercard, VISA and Discover. For patients with dental insurance, we are happy to assist in filing your dental insurance claim.

Your insurance coverage of our fee is the best **estimate** we are able to determine from your insurance carrier. Please understand however, our calculations are strictly **ESTIMATES** and **there is no guarantee that your insurance company will reimburse us according to these estimates**. Ultimately, your insurance is a contract between you and your insurance carrier. We are not a party to that contract. You are responsible for any portion of the treatment fee that your insurance company does not pay, for whatever reason.

Returned checks and balances older than 30 days will be subject to additional collection fees. Any attorney or collection fees incurred due to delinquency in payment will also be charged to the patient.

I have read this document and understand my financial responsibility for dental services provided for myself and other patients whose names I have provided to appear on my account with Drs Uhle and Niemiec.

Signed:____ Date:_____________

Robert A. Uhle D.D.S., M.S. Matthew S. Niemiec D.D.S., M.S.

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.

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 (04/14/03), 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 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, dentist, or other healthcare provider providing treatment to you. This includes staff members in our office.
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 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 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.
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 RIGHTSAccess: 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 $15 for records search and compilation, $1.00 for each page copied, $1.00 for each radiograph (x-ray) copied, 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 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 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 Officers: Robert A. Uhle or Matthew S. Niemiec
Telephone: 614-436-2277 Fax: 614-436-2322 Address: 825 High St. Worthington, OH 43085