OAK HARBOR DENTAL
DR MARK R BEDFORD, DDS INC
11707 W STATE ROUTE 163
OAK HARBOR, OH 43449
419-898-6633

Patient Information

First Name:_____Last Name:_____DOB:_____

Social Security Number:_____ Email:_____

Address:_____ZIP_____

Home#:_____Cell#:_____Work#:_____

Circle One-- Sex: MALE FEMALE Marital Status: Child Single Married

How did you hear about us?_____(if person, please state their name.)

Responsible Party Information (If above patient is a minor under the age of 18)

First Name:_____Last Name:_____DOB:_____

Address:_____ZIP_____

Home#:_____Cell#:_____Work#:_____

Relationship to patient:_____

Primary Dental Insurance Information

Insurance Policy Holder Name:_____DOB_____

Identification Number:_____Group Number:_____

Social Security Number:_____Ins. Phone#_____

Employer:_____

Secondary Dental Insurance Information

Insurance Policy Holder Name:_____DOB_____

Identification Number:_____Group Number:_____

Social Security Number:_____Ins. Phone#_____

Employer:_____

Payment Policy Acknowledgment

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. If you have dental insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. For the convenience of our patients, we offer the following method of payment of fees:

A. Payment in full by cash, check, bankcard, or alternate financing for each appointment as service is rendered.
B. When there is no insurance involved, a 5% courtesy is offered on fees over $300 if paid at the initial appointment, and paid by cash or check.
C. We accept insurance assignments, but require that the deductible, co-insurance and non-covered fees be paid at each visit. In the event of a duplicate payment, you will be reimbursed.
D. Visa, MasterCard, American Express and Discover are accepted.
E. Alternate financing accounts, such as Care Credit, are accepted and encouraged. Please ask us about this method of financing your care. We will be glad to assist you in filling out an application. Credit approval is required.
F. Services that require multiple visits: payment of ½ at the initial appointment and ½ at completion is expected.

Please be aware that any parent bringing a child to our office is legally responsible for payment of all service rendered.

It is Important that you realize…

1. Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. This office files your insurance as a courtesy to you. It is very important that you take the time to read and understand the information provided to you by your insurance company including your member handbook. All insurance companies have limits on the services they cover, and it is extremely important that you know your membership eligibility, benefits, limitations and exclusions under your specific plan.
2. Not all dental procedures are covered by insurance benefits
3. You (not the insurance company) are responsible to us for all of our fees for services rendered to you.
4. Procedures planned may change during the course of treatment due to unforeseen circumstances. Changes may affect the cost of care.
5. For patients who have insurance, an **ESTIMATE** will be given of the benefits that the insurance company is expected to pay, and any co-payment when requested by the patient.

We will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program in receiving this care.

We appreciate the opportunity to serve you.

_____ _____

Patient or responsible party Date

PATIENT APPOINTMENT AGREEMENT
OAK HARBOR DENTAL

We make every effort to value your time and schedule your appointment time just for you. We truly appreciate your courtesy of giving us 24 hours notice if you have a conflict with your appointment and need to schedule a different day or time. We are committed to your oral health and keeping your scheduled appointments allows us to be partners in your dental care.

• I acknowledge my appointment is a reservation.
• I acknowledge I am required to provide 24 hours notice to make any changes to my appointment.
• I acknowledge after 3 appointments in which I do not provide 24 hours notice, I may be dismissed from the practice as a patient.

_____

Patient Signature Date

Patient Medical Information

Allergic to:

Acrylic
Amoxicillin
Aspirin
Augmentin
Barbiturates/Sleeping Pills
Bactrim
Biaxin
Bleach
Ceclor
Celebrex
Cephalexins (Kelex)
Clinimycin
Codeine
Epinephrine
Erthromycin
Iodine
Latex
Metals
NSAIDS
Novacaine
Penicillin
Septocaine
Sulfa Drugs
Tetracycline
Toothpastes
Other:_____

_____

Do you have, or have had, any of the following?

AIDS/ HIV Infection
Alcohol/Drug Abuse Anemia
Ankles Swell
Anorexia
Arthritis
Artificial Heart Valves Asthma
Back Problems
Blood Clotting Problems
Blood Disease
Bronchitis
Cancer
Cardiac Pacemaker Chemical Dependency Chest Pain upon Exertion
Circulatory Problems
Damaged Heart Valve
Diabetes
Emphysema Endocarditis
Environmental Allergies
Epilepsy
Fainting Spells
Cold Sores/Fever Blisters
Frequent Headaches
Frequent Dry Mouth Gag Reflex
Heart Attack
Heart Disease/ Angina
Heart Murmur
Heart Stents Hemophilia
Hepatitis
High Blood Pressure
Hives/Skin Rash
Jaw Pain/TMJ
Joint Replacement
Kidney/Bladder Trouble
Liver Disease
Low Blood Pressure
Mitral Valve Prolapse
Paget's Disease of Bone
Persistent Diarrhea
Premedicate
Radiation Treatment
Respiratory Disease
Rheumatic Fever / Rheumatic Heart Disease
Swollen Neck Glands Sinus Trouble
Seizures
Shingles
Shortness of Breath
Smokeless Tobacco Users
Smoker
Stroke
Tuberculosis
Thyroid Problems
Ulcer

Are you under the care of physician now? Y or N
Explain _____
Have you ever been hospitalized or had a major operation? Y or N
Explain_____

_____

Are you taking any medications, pills, drugs? Y or N
List: _____

_____

_____

_____

_____

Do you use tobacco?
Y or N
Do you use controlled substances? Y or N
Have you had a serious neck injury? Y or N
Explain _____
Women: Are you pregnant? Y or N Nursing? Y or N
Taking Oral contraceptives? Y or N
Physician's Name:

_____

Telephone Number:

_____

Emergency Contact

_____

Telephone Number:

_____

Date _____
Signature

_____

_____

Oak Harbor Dental

HIPAA uses and Disclosures of Protected Health Information

Any information noted below will only be used at Oak Harbor Dental.

HIPAA Privacy Rules gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Patient Name: _____Date of Birth:_____

Patient Address:_____ Minor (Under age 18): ___Yes ___No

Home Phone:_____Work Phone:_____

Cell Phone:_____Email:_____

ADDITIONAL PATIENT INFORMATION

Emergency Contact:_____

Emergency Contact Phone:_____

ORAL COMMUNICATION: Oak Harbor Dental will try contacting the patient via phone at either the home, cell or work number. Please indicate which phone number (or numbers) you prefer us to use and the best time of day to reach you.

_____

If you are unable to be reached, Oak Harbor Dental will leave call back instructions with minimal information. If this is not acceptable, please indicate what is acceptable for a phone message.

_____

_____

WRITTEN COMMUNICATION: Written communication from Oak Harbor Dental is sent to the home address. If this is not acceptable, please indicate another address.

_____

PERMISSION TO DISCUSS HEALTH INFORMATION WITH OTHERS: I permit the dental office to discuss my PHI with, and to disclose my PHI and/or pick up my prescriptions to the following individual(s).

__Spouse: Name: _____ ___All PHI___RX only
__Adult Child: Name: _____ ___All PHI___RX only
__Other: Name: _____ ___All PHI___RX only
__Parents: Name: _____ ___All PHI___RX only

NOTE: Proof of documentation may be needed if restrictions apply.

Signature of Patient or Legally Authorized Representative: _____
Relationship to Patient: _____ Date: _____
***This form is only meant to be a quick-reference tracking tool for the dental office.**
☐ **Individual refused to sign. Reason:_____**

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Composite (white) restorations on back teeth are many times downgraded by some insurance companies. Please know that if you have insurance you are responsible for any amount not allowed/ covered by your insurance.

_____ Date:_____
Patient Signature or Responsible adult if child