EMERGENCY PATIENT INFORMATION (Confidential and Necessary) Date:___/___/___

Name: ______________________________ Birth Date:___/___/___Age:__________
Home Address____________________City____________State __________
Zip______
Phone Numbers: Home_____-_____-_____Work_____-_____-_____Cell_____-_____-_____
e-Mail Address____________@____________Social Security Number:____-____-____
Your Employer____________________Position____________How Long?__________
Employer Address______________City__________State__________ZIP__________
Spouse/Parent/Guardian (circle one)______________________________________
Their Employer______________Position __________How
Long?__________________
Their Employer Address ____________City____________State__________
ZIP__________
Nearest Relative Not Living With You__________________Relationship__________
Their Phone Number_____-_____-_____City______________State__________
Whom Should We Contact In An Emergency?______________Phone:_____-_____-_____
Physician______________________________________Phone:_____-_____-_____
Person Responsible For This Account ______________________________(signature)

Craig Callen D.D.S. & Associates

DENTAL INSURANCE INFORMATION (TO PROCESS YOUR CLAIM)
Primary Dental Ins. Co.______________Employer______________Group__________
Phone_____-_____-_____Annual Benefit Maximum__________Annual Deductible__________

Whom May We Thank for This Referral (How did you find out about us?)______________

Reason For Call: ____Discomfort, How long?______ Swelling ____Broken Tooth/Filling
_______Bleeding _______Toothache _______Sentistive to: Hot Cold Sweet Biting
Comments:

Location of Problem: _____Upper Right _____Upper Left _____Lower Right _____Lower Left
Fee Range Given: $ _______to $ _______Payment Method: _____Cash _____Check ____Credit Card

Date	***Tooth#***	***Treatment Notes***
		Emergency Exam X-Ray Flim # Panorex
		Rx: Antibiotic: Pain Meds:
		Other:
		Refer To: CAESY:

PATIENT MEDICAL HISTORY	**MEDICAL ALERTS !**
Date: / / Blood Pressure: / (taken by our office)	

Patient Name: Age: Weight: Height:

Question		
1.) Have you been hospitalized in the last 5 years? Why?______	YES	NO
2.) Are you taking any medications? What? ______	YES	NO
3.) Are you allergic to any medications? What?______	YES	NO
4.) Do you use alcohol? How much a week? ______	YES	NO
5.) Do you use tobacco products? How much a day? ______	YES	NO
6.) Have you had any allergies or problems with Novocaine?______	YES	NO
7.) Have you had any allergies to Latex? ______	YES	NO
8.) Do you have any problem bleeding a long time if you cut yourself?______	YES	NO
9.) **WOMEN:** Are you pregnant, or think you may be? What month? ______	YES	NO
Are you taking birth control pills?______	YES	NO

10.) IF YOU HAVE HAD ANY OF THE FOLLOWING PROBLEMS, PLEASE CIRCLE THE CORRECT RESPONSE. IF SOMEONE IN YOUR FAMILY HAS HAD THE PROBLEM, PLEASE WRITE AN "F" FOR FAMILY NEXT TO THE CORRECT RESPONSE. THANK YOU.

Heart Disease or Attack	Jaundice or Liver Disease	Diabetes
Angina (Chest Pain)	Hepatitis A	Tuberculosis
Heart Murmur	Hepatitis B	Arthritis
Mitral Valve Prolapse	Hepatitis Non A,B	Rheumatism
Artificial Valve	A.I.D.S. or H.I.V.	Artificial Joints (or pins)
Pacemaker	Blood Transfusion	Cancer
High Blood Pressure	Hemophilia	Radiation Therapy
Low Blood Pressure	Venereal Disease	Chemotherapy
Swollen Ankles	Sinus Problems	Drug or Alcohol Problems
Anemia	Asthma	Psychiatric Treatment
Thyroid Disease	Hay Fever/ Allergies	Fainting or Dizziness
Glaucoma	Ulcers	Epilepsy

NOTES:______

Question		
11.) Do you get shortness of breath, or chest pain walking up stairs?______	YES	NO
12.) Do you need to prop yourself up with pillows to sleep?______	YES	NO
13.) Do you have any health problems not listed? What? ______	YES	NO

To the best of my knowledge, all of the preceding answers are true and correct. I will inform the doctor if there are any changes in my health, or medicines at my next appointment. I am also now aware that the doctor may take pictures for diagnosis and documentation purposes and that I give my permission for these pictures to be used for educational and scientific purposes. I authorize the insurance company to pay the dentist benefits payable to me for services rendered and authorize the use of this signature for insurance submission. I authorize release of information to the insurance company. I understand that I am financially responsible for my treatment regardless of what my insurance may or may not pay.

Patient (Parent) Signature: Dr.

Craig C. Callen, D.D.S. & Associates

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy as a patient. Implementation of HIPAA requirements offcially began on April 14, 2003, While we have followed these policies for years, there have been a few updates that we wanted you to be aware of. This is a shortened version of the HIPAA policy. The full policy is available for your review if you would like.

There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal exchange of information within our office. HIPAA provides certain rights and protections to you as the patient. We follow these guidelines and provide you with the quality care you deserve. Additional information is avaliable from the U.S. Department of Health and Human Services. You can find them online at www.hhs.gov

This summarizes our policy here at Craig C. Callen, D.D.S. & Associates.

Patient information will be kept confidential except when it is necessary to provide services or to ensure that all administrative matters related to your care are handled properly. This may include, but not limited to, the sharing of information with other healthcare providers, laboratories, and health insurance companies. Patient information (treatment plans, insurance forms, eob's etc.) may be stored in file cabinets not accessible by patients. Preparing for and during your dental visit such records may be left, at least temporarily, in administrative areas such as the front office, doctors desk, examination room,etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

We send out reminders to our patients. We do this by one or more of the following; e-mail, texting, calling, and sending postcards. We try to make every effort to remind you of your appointment and any treatlment that you need. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative. We also may send out newsletters or special promotions that we are offfering.

You agree to us sending electronic e-referrals to specialists, which include your PHI and x-rays, if needed. We also send electronic claims to your dental insurance, which includes submitting PHI to receive payment for services provided.

You give us permission to remind you to take pre-medication prior to appointmants, if applicable.

You give us permission to call in any prescriptions you may need and share your PHI with the pharmacist.

The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAAA.

You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor, and understand that you have the right to file a complaint. We can help you do this, and you will not be penalized for filing a complaint.

Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services without your permission.

We agree to provide patients with access to their records in accordance with state and federal laws. We may update this policy as needed to better serve the needs of our patients and our practice.

By signing below, I agree that, I have been offered the HIPAA policy, and understand and acknowledge my agreement to the terms set forth in the HIPAA information and consent form and any future update to this policy.

Patient: ____

Signature: ____

Date: ________________

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize Craig C. Callen & Assoc. L.L.C. to disclose your PHI to the following individuals (check all that apply).

Name: ______________________________ **Relationship to Patient:** ______________
Telephone: (______)______________ **Email:**______________________________
Types of Information: ☐ Appointment Reminders ☐ Results (X-Ray, etc) ☐ Financial ☐ Other: __________
Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: __________

Name: ______________________________ **Relationship to Patient:** ______________
Telephone: (______)______________ **Email:**______________________________
Types of Information: ☐ Appointment Reminders ☐ Results (X-Ray, etc) ☐ Financial ☐ Other: __________
Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: __________

Name: ______________________________ **Relationship to Patient:** ______________
Telephone: (______)______________ **Email:**______________________________
Types of Information: ☐ Appointment Reminders ☐ Results (X-Ray, etc) ☐ Financial ☐ Other: __________
Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: __________

☐ **None of the above** **Signature:** ______________________________

Dr. Craig Callen & Associates

552 South Trimble Road

Mansfield, Ohio 44906

DELINQUENT ACCOUNT:

Any delinquent account may be placed with a collection agency if we are unable to work out a financial solution. Accounts placed with a collection agency will be assessed an additional charge up to 1.5% per month. If your account is placed with a collection agency and legal action is initiated, you will be responsible for any amount due, including but not limited to interest, fees, and/or expenses incidental to the principal obligation prior to a judgment being rendered against you.

BROKEN APPOINTMENTS:

When you miss an appointment or change on short notice, it affects many people. The time is reserved just for you. Missed appointments delay your treatment, but it also takes time away from other patients and leads to higher overhead and increased fees. **We request a two day notice of any change.**

Our policy is:

1st broken appointment/short notice change - We will waive our usual $100 missed appointment/late cancellation fee. **We request a two day notice of any change.**

2nd broken appointment/short notice change - A $100 charge will be reflected on your statement and a $100 deposit for reserving your next appointment time.

3rd broken appointment/short notice change - A $100 charge on your statement plus a $100 deposit for reserving your next appointment time. If you are unable to keep this appointment and do not give us at least 2 business days notice you will forfeit this deposit.

Of course, we understand there are legitimate reasons patients have to occasionally miss appointments. Every situation will be weighed on its own merits.

Thank you for understanding our policy and for your consideration.

I/We the undersigned acknowledge and agree to the terms and conditions of Craig C. Callen, D.D.S. & Associates including but not limited to the fees and conditions contained herein.

Patient Signature_________________________ Date________________________________

Updated 3/2022