

**Welcome to our office!** In order to get to know you better and to give you the most consideration of your time, please complete both sides of this form. All information is, of course, confidential.



Dental Group, Ltd.

**O'Brien Conroy Dental Group, Ltd.**  
6790 Perimeter Drive, Suite 100  
Dublin, OH 43016  
614-717-3500 • 614-717-0933 (fax)  
[www.drSOC.com](http://www.drSOC.com)

## PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Preferred First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ E-Mail Address : \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work/Mobile Telephone: \_\_\_\_\_

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

Male    Female    Minor Child    Single    Married    Divorced    Widowed

## PERSON RESPONSIBLE FOR ACCOUNT

Relationship to patient: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Home Telephone: \_\_\_\_\_ Work/Mobile Telephone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No. : \_\_\_\_\_ E-Mail: \_\_\_\_\_

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

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security No. : \_\_\_\_\_ E-Mail: \_\_\_\_\_

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

**DENTAL INSURANCE:**    Yes    No

**SECONDARY INSURANCE:**    Yes    No

Insured Person: \_\_\_\_\_

Insured Person: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_

Group Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

In case of an emergency whom should contact: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**HOW DID YOU LEARN ABOUT OUR PRACTICE?** \_\_\_\_\_

*Please complete the Health History on the reverse of this page*

**HEALTH HISTORY for Patient:** \_\_\_\_\_

Are you aware of any particular dental problems? \_\_\_\_\_ Are you having any discomfort or pain? \_\_\_\_\_

How long has it been since you last visited a dental office? \_\_\_\_\_ Who was your previous dentist? \_\_\_\_\_

May we ask why you left? \_\_\_\_\_

Has any dental treatment ever been recommended that hasn't been done?  Yes  No

How do you feel about having dental work done?  DREAD IT  WORRY ABOUT IT  DON'T MIND

If you could change your smile, how would you want it to look? \_\_\_\_\_

Your physician's name: \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medications that you may be taking, could have an important interrelationship with the dental treatment you receive. Thank you for answering the following questions.

Are you under a physician's care now?  Yes  No  N/A \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No  N/A \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No  N/A \_\_\_\_\_

Are you taking any medication, pills or drugs?  Yes  No **IF YES PLEASE LIST THEM IN THE COMMENTS SECTION BELOW**

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No

Do you use tobacco?  Yes  No

Have you ever taken Fosamax, Boniva, Actonel  Yes  No or any other medications containing bisphosphonates?

Do you use controlled substances?  Yes  No

Are you on a special diet?  Yes  No

**Women: Are you**  Pregnant  Nursing  Taking oral contraceptives

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Other \_\_\_\_\_

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

- |  |  |  |   |   |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV                | <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Frequent Headaches    | <input type="checkbox"/> Irregular Heartbeat    | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Alzheimer's Disease     | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Kidney Problems        | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Anaphylaxis             | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Leukemia               | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Angina                  | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Heart Murmur*         | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Arthritis/Gout          | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Pace Maker*     | <input type="checkbox"/> Lung Disease           | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Artificial Joint*       | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Osteoporosis           | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Pain in Jaw Joints     | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Parathyroid Disease    | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Blood Transfusion       | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Psychiatric Care       | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Breathing Problems      | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Radiation Treatment    | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Bruise Easily           | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Recent Weight Loss     | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Renal Dialysis         | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatic Fever*       | <input type="checkbox"/> Yellow Jaundice            |
|  |  |  | <input type="checkbox"/> Rheumatism             |   |

\* Condition may require pre-medication N/A – not answered by patient

Have you ever had any serious illness not listed above?  Yes  No  N/A \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent or guardian \_\_\_\_\_

Date \_\_\_\_\_



Dental Group, Ltd.

O'Brien Conroy Dental Group, Ltd.  
6790 Perimeter Drive, Suite 100  
Dublin, OH 43016  
614-717-3500 • 614-717-0933 (fax)  
[www.drsoc.com](http://www.drsoc.com)

### HIPAA CONSENT

I give permission to the doctors and staff of O'Brien Conroy Dental Group, Ltd. to leave voicemail messages and mail reminder postcards concerning my appointments and any appointments for my dependant children. I understand it is my responsibility to inform the office of any changes in this information. Please leave information at the following phone numbers and address:

_____	home	work	cell	other
_____	home	work	cell	other
_____	home	work	cell	other

Home address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail (optional for reminders) \_\_\_\_\_

Text messages (optional for reminders) \_\_\_\_\_

Child(ren)'s or ward(s) name(s) is/are: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I give permission to O'Brien Conroy Dental Group, Ltd. to discuss my treatment, charges and all necessary information related to my care with the following person (consent may be revoked at any time per the patient's request in writing).

Name(s): \_\_\_\_\_

I also acknowledge that I have received a copy of and understand the HIPAA Privacy Policy for O'Brien Conroy Dental Group, Ltd.

\_\_\_\_\_  
Patient, Parent or Guardian Signature

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Date



Dental Group, Ltd.

**O'Brien Conroy Dental Group, Ltd.**

6790 Perimeter Drive, Ste. 100  
Dublin, OH 43016  
614-717-3500 • 614-717-0933 (fax)

**CONSENT FOR TREATMENT  
INSURANCE RELEASE/AUTHORIZATION**

I give my permission for the dentists and staff of O'Brien Conroy Dental to treat me, including any procedure(s) as deemed necessary in the exercise of their professional judgment. Please check or initial each item.

- \_\_\_\_\_ I understand that dental care requires my cooperation, and I will follow my dentist's orders and prescriptions. If indicated, I will make and keep appointments for follow-up care and call the office to note any changes or concerns in my condition.
- \_\_\_\_\_ I authorize my dentist and O'Brien Conroy Dental to use photography/video tape or other similar means to record my procedure(s). I understand that reproduction or publication of said photographs and recordings will be used for the purpose of insurance predeterminations, patient education, before and after dental portfolios and/or documentation for my dental record and require an additional consent/release for any publication.
- \_\_\_\_\_ I further acknowledge that all recorded media obtained is the sole property of O'Brien Conroy Dental. All x-rays photos, etc. are to be maintained by O'Brien Conroy Dental Group, Ltd., as required by law. Patients are entitled to copies of any/all patient materials.
- \_\_\_\_\_ I hereby certify that I have read the foregoing CONSENT and fully understand the contents thereof.

Patient Name: (Print) \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Parent or Guardian's Signature: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION AND RELEASE**

- \_\_\_\_\_ I have read and understand the consent forms that have been provided to me by the dentists and staff of O'Brien Conroy Dental.
- \_\_\_\_\_ I authorize my dentist to release any information, including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers.
- \_\_\_\_\_ I authorize and request that my insurance company, in lieu of reimbursing me directly, pay to the dentist or dental group any benefits for services rendered.
- \_\_\_\_\_ I understand that my dental insurance carrier may pay less than the actual bill for services. I agree that I may be responsible for payment of all services rendered on my behalf or my dependents.
- \_\_\_\_\_ I have received, read and fully understand the financial policy (*located on the last page*) and payment options for O'Brien Conroy Dental.

\_\_\_\_\_  
Signature of Patient or Parent (if Minor)

\_\_\_\_\_  
Date



Dental Group, Ltd.

**O'Brien Conroy Dental Group, Ltd.**

6790 Perimeter Drive, Suite 100

Dublin, OH 43016

614-717-3500 • 614-717-0933 (fax)

[www.drSOC.com](http://www.drSOC.com)

### **BROKEN APPOINTMENT POLICY**

Your appointment time has been reserved especially for you. If you are unable to keep your appointment, please notify our office **at least 24 hours** in advance. Our primary goal is patient care, and as a courtesy our staff will **attempt** to confirm your appointment, but it is the patient (or guardian's) sole responsibility to confirm and keep scheduled appointments. Our practice has an after hour voicemail system that patients can utilize by calling 614-717-3500 for the purpose of notifying us of your need to reschedule an appointment.

**Broken/missed appointments, late arrivals (more than 15 minutes after your scheduled appointment), and appointments canceled with less than 24 hours notice will be charged \$40 per hygiene appointment and \$80.00 per hour per doctor appointment.**

By not canceling in a timely manner, our practice is unable to fill those appointment times with other patients who are eager to be cared for in our practice. It is necessary for us to enforce this policy in order to be fair to all our current and future patients. As the demand grows for our services, this policy will decrease the waiting time for all patients and help ensure availability and prompt care. We understand situations arise that may not permit you to give us adequate notice. Exceptions to this policy will be determined on an individual basis according to the circumstances.

I have read and understand the broken appointment policy. By signing below, I acknowledge that I will make every effort to notify the dental staff at least 24 hours in advance if I will not be able to make my scheduled appointments. I also understand that if I break three appointments without notice, I may be asked to separate from the practice.

\_\_\_\_\_  
Patient Signature (or guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

Last updated: 4/12/2019

## FINANCIAL POLICY FOR O'BRIEN – CONROY GENERAL DENTISTRY

The dentists at O'Brien Conroy dental group are network providers for the following insurance plans:

<b>Aetna PPO (Aetna Dental Admin / Sunlife)</b>	<b>Anthem (Complete, Prime, Grid Plus, Traditional PPO)</b>
<b>Assurant / Fortis / DHA</b>	<b>Cigna PPO</b>
<b>Connection / GEHA / 32Dental / Ametitas / Reliance Standard / Principal / Lincoln</b>	<b>Delta Premier</b>
<b>Delta Dental DPO/PPO</b>	<b>Metlife PDP</b>
<b>Guardian / Dental Guard / Jefferson Pilot / Fiserv</b>	
<b>Humana (NOT ACCEPTED: Federal Humana, Humana Advantage, Humana DMO plans)</b>	

We also accept any traditional indemnity plans, which allow their subscribers complete freedom of choice of providers.

We do not accept DMO or HMO dental plans. If you have signed up for either of these plans, you have been assigned a primary care dentist or you will have to choose from a list of DMO/HMO providers. Any services performed for patients with DMO or HMO dental plans are not covered in our office and will be the responsibility of the patient.

We routinely file claims and accept insurance payments as a courtesy to our patients. Please note that some plans have yearly maximums, deductibles, waiting periods, limitations, alternate benefits, and missing tooth clauses that may limit your benefits. Our staff does its best to obtain as much information about your plan from the insurance company, but you are ultimately responsible for knowing your coverage. Consult the carrier, your HR person, or your benefit plan book for more information regarding your plan.

### **UNDERSTANDING INSURANCE**

We understand insurance can be very confusing. We are happy to assist in maximizing your dental benefits, but your insurance plan is a contract between you, your employer, and the insurance carrier.

This is where the confusion may begin. Some patients believe that the filing, tracking, and collection for their insurance rests solely on the medical or dental office. The ADA, AMA, your HR representative, and even your insurance carrier will confirm this is **your** insurance policy and you are the responsible party. To help minimize confusion and assist as much as possible, we do submit pre-determinations of benefits, and we can check by phone and/or website to verify and gain information for you. We suggest that you research this information on your own and know your insurance plan and the benefits it provides. Your HR department is your best source of information.

### **PROTOCOL AND POLICIES**

We ask that you provide accurate insurance information prior to or at the time of arrival for your appointment. We will file your claim at our expense as a courtesy. We will try to obtain as much information about your plan as the carrier will allow. After 30 days have elapsed we will research and re-file your claim if necessary. At 30 to 45 days, we will send you a letter informing you of any problems and ask that you become involved with your insurance company. At 60 days we ask that you satisfy the balance if no payment has been made by the insurance company. We will re-file or appeal without any expense to you, and direct the monies to you since you have met your obligation to us. In the unfortunate event any account reaches 90 days we will attempt to provide you a final notice. On the 97<sup>th</sup> day we will reluctantly forward this to an outside collection agency. ***Patients will be charged up to 50% of the collection agency fee should the account(s) be sent to a third party agency for the purpose of collecting any outstanding debt over 90 days.***

***Patient co-payments are due on the day services are rendered*** to help control costs associated with billing and collections and to comply with contractual provisions of multiple insurance carriers. For these co-payments we accept the following forms of payment: Cash, Check, Mastercard, Visa, American Express, Discover, and interest free payment plans up to 6 months through Card Credit Finance (applications available at front desk).

**REMINDER: Broken/missed appointments, late arrivals (more than 15 minutes after your scheduled appointment), and appointments canceled with less than 24 hours notice may be charged \$40 per hygiene appointment and \$80.00 per hour per doctor appointment.** If you are unable to keep your appointment, please notify our office **at least 24 hours** in advance by calling 614-717-3500.



Dental Group, Ltd.

**O'Brien Conroy Dental Group, Ltd.**

6790 Perimeter Drive, Suite 100

Dublin, OH 43016

614-717-3500 • 614-717-0933 (fax)

[www.drSOC.com](http://www.drSOC.com)

## HIPAA Privacy Policy

This notice describes how personal health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

It is the policy of our practice that the dentist and staff preserve the integrity and confidentiality of **Protected Health Information (PHI)** pertaining to our patients. The purpose of this policy is to ensure that our practice and its dentists and staff have the necessary medical and PHI to provide the highest quality dental care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its dentists and staff for the purpose of **Treatment, Payment and dental Operations (TPO)**. To that end, our practice, its dentists and staff will:

1. Adhere to the standards set forth in the Notice of Privacy Practices.
2. Collect, use and disclose, PHI only in conformance with state and federal laws, and current covenants and/or authorization from the patient (or parent/guardian).
3. Remind patients of their appointments and file insurance on their behalf unless they instruct us not to do so.
4. Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice, its dentists and staff will:
  - a. Implement reasonable measures to protect the integrity of all PHI maintained about patients.
5. Recognize that patients have a right to privacy. Our practice and its dentists and staff respect the patient's individual dignity at all times. Our practice and its dentists and staff will respect the patient's privacy to the extent consistent with providing the highest quality dental care possible and with the efficient administration of the facility.
6. Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its dentists and staff will:
  - a. Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
  - b. Not disclose PHI data unless the patient (or his/her authorized representative has properly authorized the release, or the release is otherwise authorized by law.
7. Recognize that, although our practice "owns" the dental records, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her dental record if he/she believes his/her is inaccurate or incomplete. Our dentists and staff will:
  - a. Permit patients access to their dental records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site dental professional review the patient's appeal.
  - b. Provide patients an opportunity to request the corrections of inaccurate or incomplete PHI in their dental records in accordance with the law and professional standards.
8. The dentists and staff of our practice will maintain a list of certain disclosures of PHI for the purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rule. We will provide this list to patients upon request, so long as their requests are in writing.
9. The dentists and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that our patients have requested and have been approved by our practice.
10. The dentists and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.
11. The dentists and staff of our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.