PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION

First Name:_____Middle Initial:_____Last Name:_____

Date of Birth: _____ Social Security Number: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other: _____ Sex: ☐ Male ☐ Female

Street Address: _____ Phone Number: _____

City, State, Zip Code: _____County: _____

Email Address: _____@_____

Preferred Language: _____

Gender Identity (please check one): ☐ Male ☐ Female ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female ☐ Other ☐Choose not to disclose.

Sexual Orientation (please check one):☐ Lesbian or Gay ☐ Straight ☐ Bisexual ☐ Other ☐ Don't know ☐ Choose not to disclose.

Race (please check one): ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ American Indian/Alaska Native ☐ Other:_____

Ethnicity (please check one): ☐ Hispanic ☐ Non-Hispanic

Veteran (please check one): ☐ YES ☐ NO Check if one of these apply: ☐ Homeless ☐ Seasonal Worker ☐ Migrant.

PARENTS/LEGAL GUARDIANS – this section *MUST be completed if patient is under 18 years of age.*

Mother's Name:_____DOB: _____

Social Security Number:_____ Phone Number: _____

Street Address: _____

City, State, Zip Code: _____ County: _____

Father's Name:_____DOB: _____

Social Security Number_____ Phone Number: _____

Street Address: _____

City, State, Zip Code: _____ County: _____

Legal Guardian Name: _____DOB: _____

Social Security Number:_____ Relationship to Patient: _____

Street Address:_____ Phone Number: _____

City, State, Zip Code: _____ County: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ DOB: _____

Relationship: _____ Phone Number: _____

HOUSEHOLD INFORMATION

Because we receive some funding to offset the costs of treating uninsured or underinsured patients, we are required to report certain demographics on all our patients including race, family size, and income. Reporting these items assists us to receive funding to continue providing care to all of our patients. Reported information does not contain your name, address, or social security number.

PLEASE CHECK THE APPROPRIATE INCOME LEVEL FOR YOUR HOUSEHOLD

Household Members	Nominal Fee (100% Adjustment)	Pay 25% (75% Adjustment)	Pay 50% (50% Adjustment)	Pay 75% (25% Adjustment)	Pay 100% (0% adjustment)
1	0- $14,580	$14,581-$18,225	$18,226-$21,870	$21,871-$29,160	$29,161
2	0- $19,720	$19,721-$24,650	$24,651-$29,580	$29,581-$39,440	$39,441
3	0- $24,860	$24,861-$31,075	$31,076-$37,290	$37,291-$49,720	$49,721
4	0- $30,000	$30,001-$37,500	$37,501-$45,000	$45,001-$60,000	$60,001
5	0- $35,140	$35,141-$43,925	$43,926-$52,710	$52,711-$70,280	$70,281
6	0- $40,280	$40,281-$50,350	$50,351-$60,420	$60,421-$80,560	$80,561
7	0- $45,420	$45,421-$56,775	$56,776-$68,130	$68,131-$90,840	$90,841
8	0- $50,560	$50,561-$63,200	$63,201-$75,840	$75,841-$101,120	$101,121

☐ Sliding Fee application must be returned within 2 weeks of appointment with proof of income.

Patient Name:_____ D.O.B.:_____

INSURANCE INFORMATION

Policyholder Name: _____ D.O.B.:_____

Primary Insurance:_____ ID#:_____ Group#:_____

Secondary Insurance:_____ ID#:_____ Group#:_____

EMPLOYER INFORMATION

Employer Name:_____ Phone#:_____

Address:_____ Date of Hire:_____

PAYMENT GUARANTEE-MUST be signed!

I hereby verify that all information provided by me is true and correct to the best of my knowledge. I authorize ONE Health Ohio to make any investigation necessary to verify my eligibility for financial assistance or insurance coverage with my account. If the insurance or financial assistance information provided by me is false, I agree to pay for all services rendered (the sliding fee scale discount will be reversed to the appropriate pay status).

I consent to any services rendered to me or my dependents by the attending provider/physician. I agree to pay all fees and charges for such treatment promptly upon presentation of charges unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless disputed in writing within thirty days of billing date. I hereby authorize that my insurance benefits be paid directly to ONE Health Ohio. I realize that I am responsible to pay for all non-covered services. I also authorize the release of any pertinent medical information to insurance carriers necessary to process payment for professional services rendered by ONE Health Ohio.

Patient/Parent/Legal Guardian Signature:_____ Date: _____

Staff Witness Signature:_____ Date: _____

ONE HEALTH OHIO HIPAA PRIVACY PRACTICES

In general, the Health Insurance Portability and Accountability Act (HIPAA) privacy rule gives individuals the right to request a restriction on the uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of his/her home address. The privacy rule generally requires health care providers to take reasonable steps to limit the use or disclosure of PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses of disclosures made pursuant to an authorization requested by the individual. *Uses and disclosures may be permitted without prior consent in an emergency.*

I authorize ONE Health Ohio to contact me using the contact information, which I have provided on my demographic form.
Please provide the forms of communication we may contact you by:
This includes but is not limited to letters to my address, email, cell phone, home phone, and work phone calls including detailed messages on my voicemail or answering machine.

_____ _____

_____ _____

Individuals Authorized to Receive My Health Information

I agree to let ONE Health Ohio communicate with the following individuals on my behalf. *Should any of these individuals need to pick-up or drop-off personal information, up to and including prescriptions, they understand they must provide proper identification that coincides with their information below.*

Name/Relationship:_____Phone#:_____DOB: _____

Name/Relationship:_____Phone#:_____DOB: _____

Please sign and date the acknowledgement below. Thank You

I,_____,(printed name of the patient or guardian) acknowledge and agree that I have received a copy of ONE Health Ohio's Notice of Privacy Practices and agree to be contacted in the manners listed above.

Patient Name:_____ Patient DOB: _____

Patient Signature:_____ Date Signed: _____

Guardian Signature:_____ Guardian DOB: _____

Relationship to patient: _____ Date Signed: _____

For Center Use

ONE Health Ohio has made the following good faith effort to obtain the above referenced individuals written acknowledgement of receipt of Privacy Practices.

☐ Individual refused to sign.

☐ An emergency situation prevented us from obtaining acknowledgment.

☐ Other: _____

Staff Signature:_____Date: _____

DENTAL HISTORY FORM

Patient Name:_____ Date:_____

What is the main reason for your visit today?_____

What is the date of your last dental appointment? _____

Please check any symptoms that you have had or currently have today:

____Abnormal Bleeding after Extraction
____Bad Breath/Bad Taste
____Bleeding Gums
____Broken Fillings
____Burning Mouth
____Dry Mouth
____Gum Disease
____Grinding/Clenching
____Jaw Pain/Popping/Clicking
____Loose Tooth/Teeth
____Problems Biting/Chewing
____Sensitive(hot/cold/sweets)
____Sores/Growths in Mouth
____Swelling
____Toothache

Have you ever been advised to take antibiotics before dental appointments? ☐ Yes ☐ No

MEDICAL HISTORY:

Are you currently under the care of a medical doctor? ☐ Yes ☐ No

Physician's name and phone number:_____

Please list all prior operations and hospitalizations with dates:_____

_____

WOMEN: Are you currently pregnant? ☐ Yes ☐ No If yes, due date:_____

Are you nursing? ☐ Yes ☐ No Do you take birth control pills? ☐ Yes ☐ No

Please check any of the following you have or have had:

____Abnormal Bleeding
____Alcohol Abuse
____Allergies
____Anemia
____Anxiety/Panic Attacks
____Arthritis
____Artificial Heart Valve
____Artificial Joints (knee/hip)
____Asthma
____Back Problems
____Blood Disease
____Blood Thinner Meds (Aspirin/Plavix/Coumadin,etc.)
____Cancer:_____
____Chemotherapy
____Cortisone Treatments
____Cough (persistent)
____Emphysema
____Depression
____Diabetes
____Drug Addiction
____Epilepsy/Seizures
____Fainting/Dizziness
____Glaucoma
____Headaches
____Heart Attack
____Heart Murmur
____Heart Pacemaker
____Heart Problems
____Heart Surgery
____Hemophilia
____Hepatitis A B C
____High Blood Pressure
____HIV/AIDS
____Kidney Disease
____Liver Disease
____Mitral Valve Prolapse
____Psychiatric Treatment
____Radiation Treatment
____Recreational Drugs
____Shortness of Breath
____Sinus Trouble
____Skin Rash
____Stroke
____Swelling of Feet/Ankles
____Thyroid Problems
____Tobacco:_____
____Tonsillitis
____Tuberculosis (TB)
____Ulcer
____Venereal Disease/STD
____Other:_____

Do you currently take or have you taken any medicines for your bones (Boniva,Fosamax,etc)? ☐ Yes ☐ No

Please list any prescription/non-prescription medicines, vitamins, herbs, etc. you may be taking:

_____

Please list any medications to which you have had an allergic reaction:

_____

****

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answer I have given are accurate. I also understand it is very important to report any changes or updates in my medical status.

Patient Name (Printed):_____ Patient (or parent/guardian) Signature:_____ Date:_____