DRS. JARDIN, BUGANSKI & DUGGAN

Date _____

Patient Name _____ Age _____ DOB ____/____/____

Address _____ ❑Male ❑Female

City _____ State _____ Zip _____

Home Phone _____ Work _____ Ext. _____

E-mail _____ Cell Phone _____

Social Security # _____ Marital Status _____

Referred By _____

EMPLOYMENT INFORMATION

Your Employment

Employer _____

Occupation _____

Emp. Address _____

City _____ State _____ Zip _____

SPOUSE INFORMATON

Name _____

Employer _____

Occupation _____

Address _____

City _____ State _____ Zip _____

Social Security # _____

Date of Birth _____ / _____ / _____

INSURANCE INFORMATION

Primary Dental Insurance

Person Insured _____

Ins. Co. _____

Address _____

City _____ State _____ Zip _____

Group _____

Phone _____

Secondary Dental Insurance

Person Insured _____

Ins. Co. _____

Address _____

City _____ State _____ Zip _____

Group _____

Phone _____

HEALTH HISTORY

DATE _____

Has there been any change in your general health in the last year? YES NO

Are you under the care of a physician? YES NO

Physician's Name _____

Address _____ Phone _____

Have you recently taken or are you now taking any medications? YES NO

Please list those drugs:

_____

_____

Are you allergic to penicillin, novocaine, codeine or any other drugs or medicines? YES NO

If so, please list:

_____

_____

Have you ever had any excessive bleeding requiring any special treatment? YES NO

Have you ever had: (Please circle)

Heart Trouble	Rheumatic Fever	Jaundice	Convulsions
Heart Attack	Anemia	Hepatitis	Tumors
Heart Murmur	Asthma	Diabetes	Glaucoma
Stroke	Arthritis	Venereal Disease	Kidney Disease
High Blood Pressure	Tuberculosis	Herpes	Cancer
Mitral Valve Prolapse	Knee / Hip Replacement		

_____

_____

_____

Women: Are you pregnant? YES NO What month? _____

DENTAL HISTORY

Are you having any dental pain or discomfort at this time? YES NO _____

Approximately how long has it been since your last dental appointment? _____

Name of previous dentist: _____

At this time, how do you feel about the condition of your dental health? _____

Do you use dental floss? _____

Generally, how often do you brush your teeth? _____

Have you had any bad experiences in the past pertaining to dental treatment? _____

CONSENT:

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Signature _____ Date _____

Relationship to Patient _____ Doctor _____

REVIEWED

Date _____ Date _____

Date _____ Date _____

Date _____ Date _____

RONALD E. JARDIN D.D.S
MARK A. BUGANSKI D.D.S.
THERESA R. DUGGAN D.M.D.

Our office will be using an automated text message and email system for appointment reminders. We would like to know how you would like to be reached.

Please select ONE or TWO options to help us reach you

___ Please contact me by cell phone

___ Please contact me by text message

___Please contact me by home phone

___ Please contact me at work

Name:_____

Cell Phone Number:_____

Cell Phone Carrier:(for ex:Verizon):_____

Home Number:_____

Work Number:_____

Thank you for your cooperation!

DRS. JARDIN, BUGANSKI & DUGGAN, INC.

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 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 June 1, 2002, and will remain in effect until we replace it.

We reserve the right to charge 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 or other healthcare provider providing treatment lo you.
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 at 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 lo 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 lo provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: 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 formal 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 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 June 1, 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 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 Officer: Leslie Gora **Phone:** (419) 472-5725

Address: Drs Jardin Buganski & Duggan, Inc. 4339 Talmadge Road Toledo, OH 43623

DRS. JARDIN, BUGANSKI & DUGGAN, INC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement****

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

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ **Individual refused to sign**
- □ **Communications barriers prohibited obtaining the acknowledgement**
- □ **An emergency situation prevented us from obtaining the acknowledgement**
- □ **Other (Please Specify)**

_____

_____

_____

FINANCIAL POLICY

DRS. JARDIN, BUGANSKI & DUGGAN, INC.

The following Financial Policy will become effective immediately:

PLEASE BRING YOUR INSURANCE CARDS OR PROOF OF INSURANCE WITH YOU; IF YOU DO NOT HAVE THEM YOU WILL BE RESPONSIBLE FOR ALL CHARGES IN THE OFFICE AT THE TIME OF SERVICE.

1. Dental benefits are based upon a contract between your employer and an insurance company. If you have any questions regarding your benefits we will try to assist you but, ideally, you should contact your employer or insurance company directly. **It is your responsibility to be aware of the contract benefits and limits of your insurance carrier.**
2. Dental benefits differ greatly from medical benefits. Dental insurance rarely pays 100% of the professional fee. **All patients are responsible for the non-covered portion of their fee.**
3. At the time of service, patients with benefits are asked to pay an estimate of the non-covered portion of the fee. (Unless other written financial arrangements have been made).
4. Insurance claims will be submitted by our office. Any charges submitted to the insurance carrier and not paid by the insurance company within 90 days from the date of service will become the responsibility of the patient and be due immediately. In the event of a duplicate payment or an overpayment, the proper party will be refunded in a timely manner.
5. Patients with no insurance benefits are asked to pay as services are rendered unless other written financial arrangements have been made in advance. We can assist you with a payment option plan if needed.
6. Any fees over $300 paid in full with **cash or check** (no exceptions) at or before the time of service will receive a 5% discount.
7. Some treatments requiring large dental laboratory bills may require a down payment before any appointment will be scheduled.
8. The responsibility for payment of services rendered to any dependents is with the parent or guardian who seeks treatment. In a divorce situation, any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of our office.
9. **Twenty four (24) hr advance notice is required for a Cancelled Appointment. Failure to provide adequate notice or missing an appointment may result in fee of $50 for an established patient or $80 for a New Patient. Repeated failure to comply with this policy can result in the dismissal of the patient from our practice.**

We have been and will always be sensitive to the needs of our patients. It is our goal that the above financial policy will allow us to provide quality care to our valued patients. If you have any questions or concerns about any of the above policies, or if a problem with your account should arise, please feel free to contact our office.

I have read and understand the financial policy above and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time.

_____ _____

Patient Signature (or responsible party) **Date**