

# STEPHEN C. DOWELL DDS, INC.

## WELCOME TO OUR PRACTICE!

(Please Print)

Today's date: \_\_\_\_\_ Appointment date: \_\_\_\_\_

### PATIENT INFORMATION

Patient's last name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  Mr.  Miss  Mrs.  Ms. Marital status (circle one)  
 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Single / Mar / Div / Sep / Wid

Is this your legal name?  Yes  No If not, what is your legal name? \_\_\_\_\_ (Former name): \_\_\_\_\_ Birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  M  F

Street address: \_\_\_\_\_ Social Security no.: \_\_\_\_\_ Home phone no.: \_\_\_\_\_  
 \_\_\_\_\_ ( )

P.O. box: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer Name and Address: \_\_\_\_\_ Employer phone no.: \_\_\_\_\_  
 \_\_\_\_\_ ( )

Referred by: \_\_\_\_\_ Reason for coming to our practice: \_\_\_\_\_

Family  Friend (name)  Close to home/work  Yellow Pages  Other

Other family members seen here: \_\_\_\_\_

### INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person responsible for bill: \_\_\_\_\_ Birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Address (if different): \_\_\_\_\_ Home phone no.: \_\_\_\_\_  
 \_\_\_\_\_ ( )

Is this person a patient here?  Yes  No Social Security Number: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer address: \_\_\_\_\_ Employer phone no.: \_\_\_\_\_  
 \_\_\_\_\_ ( )

Is this patient covered by DENTAL insurance?  Yes  No Name of insurance company: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_ Subscriber's S.S. no.: \_\_\_\_\_ Birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Group no.: \_\_\_\_\_ Policy no.: \_\_\_\_\_

Patient's relationship to subscriber:  Self  Spouse  Child  Other

Name of secondary DENTAL insurance (if applicable): \_\_\_\_\_ Secondary Insurance Company: \_\_\_\_\_ Group no.: \_\_\_\_\_ Subscriber's ID# \_\_\_\_\_

Subscriber's name: \_\_\_\_\_ Subscriber's S.S. no.: \_\_\_\_\_ Birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Patient's relationship to subscriber:  Self  Spouse  Child  Other

### IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Home phone no.: \_\_\_\_\_ Work phone no.: \_\_\_\_\_  
 \_\_\_\_\_ ( ) \_\_\_\_\_ ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Stephen C. Dowell DDS, Inc. or insurance company to release any information required to process my claims. I also understand that Dr. Dowell has the right to charge for broken appointments when notice is not given within 2 business days.

Signature of Responsible Party : \_\_\_\_\_ Date: \_\_\_\_\_

# Stephen C. Dowell

D.D.S., Inc.

549 2<sup>ND</sup> Street N.W. Carrollton, OH 44615 (330) 627-5005  
817 E. Lincolnway Minerva, OH 44657 (330) 868-5001  
[www.dowelldental.com](http://www.dowelldental.com)

## Patient PHI Authorization Form

I, \_\_\_\_\_  
*(Please print)* *Date of Birth*

hereby give Dr. Stephen C Dowell, DDS, Inc. permission to discuss my personal medical information with the following individual(s):

_____ Name	_____ Date of Birth	_____ Relationship to Patient
_____ Name	_____ Date of Birth	_____ Relationship to Patient
_____ Name	_____ Date of Birth	_____ Relationship to Patient
_____ Name	_____ Date of Birth	_____ Relationship to Patient

I understand that the information that may be discussed includes, but is not limited to: my health history, diagnostic results, plan of care and medical financial information unless otherwise restricted here:

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

I understand that this authorization will remain in effect until terminated by myself in writing.

\_\_\_\_\_  
*Patient/Guardian Signature* *Signature Date*



# 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 IT 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 \_\_\_/\_\_\_/\_\_\_, and will remain in effect until we replace it.

We reserve the right to change 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 to 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 of 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 to 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.