Welcome to Orange City Dentistry!

We are thankful you have chosen us for your dental care. We look forward to providing you with quality care, and our entire team is committed to ensuring positive experiences for you.

The goal of your first visit is to get to know you better and understand your dental past and preferences. We hold your comfort and care to the highest concern.

Here's what you can expect at your first visit:

Before Your First Visit
Complete the enclosed patient medical form so we can best care for you. Please note, for children under the age of 18, all forms must be completed by a parent or guardian.

Prior to your appointment, you will receive a reminder by text, phone call or email.

At Your First Visit
We are conveniently located at **909 Lincoln Circle SE in Orange City**, just north of the Orange City Area Health System.

At your visit, we will review your dental and medical information, record your current dental status through digital x-rays and diagnostic photographs as needed and provide a thorough exam. We will walk you through each step along the way, and if we are able to, we will also complete a dental cleaning for you at this first visit. Working together, we will determine the best treatment plan based on your individual needs. This includes routine, preventative dental care.

Insurance
Please inform our office if you have dental insurance coverage. If you have a dental insurance card, please bring it with you to your appointment. We work hard to be a resource for you and help you learn about your dental benefits; however, it is your responsibility to understand your dental insurance and costs associated with dental treatment. Payment for co-pays, deductibles, and other out-of-pocket fees are due on the day of service. No dental insurance? No problem! You can take advantage of our ten percent same-day discount.

Please let us know if you have any questions at any time. We are happy to help, and we look forward to seeing you!

Sincerely,

Mark Scallon, DDS
909 Lincoln Circle SE | Orange City, Iowa 51041
712-737-4177 | ocdentistry.net

ORANGE CITY DENTISTRY

Welcome to Orange City Dentistry—we're glad you're here! Please fill out both sides of this form. If you have any questions, we're happy to help!

PATIENT INFORMATION

FULL NAME ______________________________ Nickname: ____________

ADDRESS ______________________ City ____________ State _____ Zip ________

BIRTHDATE ____________ SOCIAL SECURITY # ____________ SEX: ☐ M ☐ F

PHONE Home (_____) _____-__________ Work (_____) _____-__________ Cell (_____) _____-__________

EMAIL ADDRESS ______________________________

EMPLOYER ______________________ OCCUPATION ______________

MARITAL STATUS: __________ NAME OF SPOUSE ______________________

SPOUSE EMPLOYER ________________ SPOUSE OCCUPATION ____________

PERSON RESPONSIBLE FOR ACCOUNT

☐ Check if Same as Above

FULL NAME ______________________________ Sex: ☐ M ☐ F

ADDRESS ______________________ City ____________ State _____ Zip ________

BIRTHDATE ____________ SOCIAL SECURITY # ____________ MARITAL STATUS: ________

EMPLOYER ______________________ OCCUPATION ______________

PHONE Home (_____) _____-__________ Work (_____) _____-__________ Cell (_____) _____-__________

Do you have dental insurance? ☐ Yes ☐ No

If yes, please give your card to the front office staff upon arrival.

EMERGENCY CONTACT: ____________________ **PHONE:** ______________

Who can we thank for referring you? ______________________

How did you hear about us? ☐ Website ☐ Newspaper ☐ Social Media ☐ Other

DENTAL CONSENT AND FINANCIAL INFORMATION

I hereby authorize and request dental services for the patient listed above, and I give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or his supervised staff for diagnostic purposes or dental treatment.

For my convenience, this office may release my information to my insurance company and receive payment from them. I understand that payment is due at the time of service. Other payment arrangements may be available and it is my responsibility to understand my payment obligations.

I understand that the financial information given is only an estimate. Every effort will be made to help me with my insurance, but my insurance company has the final say. I will be responsible for services not covered by my insurance.

I agree to pay finance charges of 1.5% per month (18% APR) on any balance 30 days past due for cash-pay; 60 days for insured procedures. If sent to collections, I agree to pay all related fees and court costs. I understand that treatment plans may change mid-treatment, and I will be responsible for the work actually completed.

PATIENT SIGNATURE (Parent if under 18) ______________________________ Date __________

DENTAL HISTORY

Do you have a dental problem? ☐ Yes ☐ No If yes, please describe: ____

Date of Last Dental Exam & X-rays: ___________________________ Previous Dentist: ___________________________

How frequently do you brush? ___________________________ How frequently do you floss? _________________

Are you aware of any growths or sores in your mouth? ☐ Yes ☐ No
Are you happy with the appearance of your teeth? ☐ Yes ☐ No
Does food catch between your teeth? ☐ Yes ☐ No
Do your gums bleed? ☐ Yes ☐ No
Do you have dry mouth? ☐ Yes ☐ No
Have you lost any teeth? ☐ Yes ☐ No

Have you ever had any problems or complications with your dental care in the past? ☐ Yes ☐ No
If yes, please explain: ____

What do you need to be more comfortable or relaxed during dental visits?
____

MEDICAL HISTORY

Medical Doctor___________________________________ Phone ____________________ City ______________________

1. Have you been a patient in a hospital during the last year? ☐ Yes ☐ No
2. Are you now or have you been under the care of a physician? ☐ Yes ☐ No
3. Are you taking any medications? Please list: ☐ Yes ☐ No
   ____
4. Are you allergic to penicillin, codeine, aspirin or any other drugs or medicine? ☐ Yes ☐ No
   Other: ____
5. Have you ever had any excessive bleeding requiring special treatment? ☐ Yes ☐ No
6. Do you ever have pain in your chest or shortness of breath when you walk? ☐ Yes ☐ No
7. Do you have any skin reaction to any metals on your body? ☐ Yes ☐ No
8. Do you smoke or chew tobacco? ☐ Yes ☐ No

Women Only:
1. Are you pregnant or possibly pregnant? ☐ Yes ☐ No Wk: _____
2. Are you nursing? ☐ Yes ☐ No
3. Are you taking birth control pills? ☐ Yes ☐ No

Please indicate which of the following you have had or have at present:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Alcohol/Drug Abuse	☐	☐	Fainting Spells	☐	☐	Neurological Disorders	☐	☐
Allergies	☐	☐	Fever Blisters	☐	☐	Pace Maker	☐	☐
Arthritis	☐	☐	Glaucoma	☐	☐	Psychiatric Treatment	☐	☐
Artificial Heart	☐	☐	HIV + AIDS	☐	☐	Radiation Therapy	☐	☐
Artificial Joints	☐	☐	Heart Murmur	☐	☐	Rheumatic Fever	☐	☐
Asthma	☐	☐	Heart Surgery	☐	☐	Seizures	☐	☐
Blood Transfusion	☐	☐	Hemophilia	☐	☐	Shingles	☐	☐
Bruise Easily	☐	☐	Hepatitis A	☐	☐	Sickle Cell Disease	☐	☐
Chemotherapy	☐	☐	Hepatitis C	☐	☐	Sinus Problems	☐	☐
Chest Pain	☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐
Chronic Cough	☐	☐	Kidney Problems	☐	☐	Swollen Ankles	☐	☐
Congenital Heart	☐	☐	Latex Sensitivity	☐	☐	Thyroid Problems	☐	☐
Cortisone Medication	☐	☐	Liver Disease	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Low Blood Pressure	☐	☐	Tumors	☐	☐
Diet (Any Restrictions)	☐	☐	MRSA	☐	☐	Ulcers	☐	☐
Emphysema	☐	☐	Mitral Valve	☐	☐	Venereal Disease	☐	☐
Epilepsy	☐	☐	Nervous/Anxious	☐	☐			

Do you have or have you had any disease, condition or problem not listed? ☐ Yes ☐ No If yes, please list :

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 April 15, 2003, 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.
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 to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

(Over, please)

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 format 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 copies, we will charge you $0.25 for each page, $10 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. 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 April 14, 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 you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to 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:

Mark Scallon, DDS
Telephone: 712-737-4177
Fax: 712-737-8718
E-mail: office@ocdentistry.net
Address: 909 Lincoln Circle SE Orange City, IA 51041

I received notice of and acknowledge these privacy practices as they relate to my protected healthcare information and treatment.

____

Signature **Date**

____

Printed Name

☐**Self** ☐ **Parent/Guardian** ☐**Power of Attorney**