CONTACT INFORMATION

The Division utilizes an automated telephone attendant to ensure quality customer service. Please be patient and follow the prompts. You will reach the correct staff member quicker by doing so.

Telephone: 614.292.5144 *or* 614.292.2212 Facsimile: 614.292.1103
Physical Address: 2nd Floor, Postle Hall
305 West 12th Avenue
Columbus, Ohio 43210

CANCELLATION POLICY

Appointments cancelled with less than 48 business hours notice are considered *broken appointments*.
For consultations, the patient may be dismissed from the care of the Division of Oral and Maxillofacial Surgery after two (2) broken appointments. For surgery appointments, the patient may be dismissed from the care of the Division of Oral and Maxillofacial Surgery after one (1) broken appointment.

FINANCIAL POLICY – *Resident Clinic patients refer to College of Dentistry Policy.*

Information below pertains to patients of the Dental Faculty Practice ONLY.

Patients are financially responsible for the entire balance of their treatments. Should there be an overpayment by the patient reflecting a credit balance, the patient will have the option of having that credit amount returned to them or utilized for future treatment. If a patient balance exceeds 30 days, it is considered delinquent and is subject to further collection action by an outside collection agent.

For patients without insurance, or for treatment by a doctor who is not a participating doctor on the patient's insurance plan, payment in full is required on the day services are rendered.

For insured patients, co-payment is required in full on the day service is rendered. Our billing staff will file claims on your behalf; in the event that the claim is returned, denied, or partially paid, the full balance becomes the patient's responsibility and is due within 30 days.

For divorced parents, the parent authorizing treatment for a child will be the parent responsible for the charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

The Division accepts the following forms of payment: cash, check, cashier's check, VISA, MasterCard, Discover, American Express, and CareCredit. CareCredit is a medical line of credit which may be available to you after a credit check and approval at an interest-free rate for a limited period of time. The Division does not make internal payment arrangements.

In cases of major surgery, patient may be required to pay a deposit to secure operating room time.

A NOTE ON CONSULTATIONS AND REFERRALS

The Division accepts new patients on a case by case basis based on the availability of our limited resources. At any given time, our resident clinic may or may not be accepting new patients from referral sources outside the College of Dentistry. The resident clinic always accepts patients for surgical services who are current patients of the College of Dentistry (have had a comprehensive or periodic examination within 24 months by a resident or dental student). The Division reserves the right to dictate resident-level or faculty-level care based on these resources and surgical complexity of the case.

As specialists, we require a written referral for all services. We also require a consultation prior to surgery. In all cases, your first appointment with the Division will not be for surgical services. This enables our practitioners to meet you, perform an examination, discuss treatment and anesthetic options with you, and present you with a comprehensive treatment plan including your financial liability.

DIRECTIONS

The following directions are general directions to the College of Dentistry. There is often construction in the University area. For more information visit dentistry.osu.edu/directions.

From the North

Take I-270 to SR 315 south
Take the Lane Ave. exit
From SR 315 south, turn left onto Lane Ave.
Turn right onto Olentangy River Rd.
Turn left onto John Herrick Dr.
The 12th Avenue garage is on your right and is connected to the Dental Clinics and Medical Center by a walkway bridge on the 3rd floor.

From the South

Take I-71 north to SR 315 north
Take the Lane Ave. exit
From SR 315 north, turn right onto Lane Ave.
Turn right onto Olentangy River Rd.
Turn left onto John Herrick Dr.
The 12th Avenue garage is on your right and is connected to the Dental Clinics and Medical Center by a walkway bridge on the 3rd floor.

From the East

Take I-70 West to SR 315 north
Take the Lane Ave. exit
Turn right onto Lane Ave.
Turn right onto Olentangy River Rd.
Turn left onto John Herrick Dr.
The 12th Avenue garage is on your right and is connected to the Dental Clinics and Medical Center by a walkway bridge on the 3rd floor.

From the West

Take SR 315 north
Take the Lane Ave. exit
Turn right onto Lane Ave.
Turn right onto Olentangy River Rd.
Turn left onto John Herrick Dr.
The 12th Avenue garage is on your right and is connected to the Dental Clinics and Medical Center by a walkway bridge on the 3rd floor.

ONCE YOU ARRIVE ON CAMPUS AND PARK

Take the 3rd floor walkway into the Medical Center
Turn left through glass doors labeled “Dental Clinic”
Take elevator to floor 2.
Exit elevator, turn right, and walk straight down hallway towards “Oral and Maxillofacial Surgery”
Check in at Oral Surgery reception desk

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at The Ohio State University

For Office Use Only:

EMR #: _____

PATIENT REGISTRATION

Please complete registration in its entirety. Have your insurance cards and driver's license available for scanning purposes.

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

PATIENT NAME _____
Last First Middle Maiden

PREFERRED NAME _____ BIRTH DATE _____ (Month/Date/Year)

☐ MALE ☐ FEMALE PATIENT'S S.S.# _____

PRIMARY LANGUAGE: _____ DO YOU NEED AN INTERPRETER? ☐ Yes ☐ No

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER _____

HOME ADDRESS _____

_____
City State Zip

HOME PHONE (_____) _____ CELL PHONE (_____) _____

WORK PHONE (_____) _____ PREFERRED CONTACT # ☐ Home ☐ Cell ☐ Work

EMAIL ADDRESS _____ MAY WE EMAIL YOU? ☐ Yes ☐ No

STUDENT ☐ Yes ☐ No WHERE ? _____ ☐ Full Time ☐ Part Time

OSU STUDENT I.D. # (if applicable): _____ DRIVER'S LICENSE #: _____

PATIENT'S EMPLOYER _____ MAY YOU BE CONTACTED AT WORK? ☐ Yes ☐ No

OSU EMPLOYEE I.D. # (if applicable) _____

EMERGENCY CONTACT/RELATIONSHIP _____ PHONE_____

PRIMARY CARE PHYSICIAN _____ _____
First Name Last Name Telephone Number

PHARMACY NAME/LOCATION _____ _____
Telephone Number

Do you have family members who are patients of our practice? ☐ Yes ☐ No If yes, name of patient(s) _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE

☐ Referred by Dentist or Physician ☐ Advertisement ☐ Internet/Website ☐ Family Member/Friend

☐ OSU Employee Benefit Fair ☐ Other: _____

Referral's Name (Person or Advertisement Source): _____

Patient Signature: _____ Date: _____
If patient is a minor, parent's signature

INSURANCE INFORMATION

Please Complete All Applicable Information & Have Your Insurance Card(s) Available For Our Office To Scan

Primary Dental Insurance ☐ **I DO NOT HAVE DENTAL INSURANCE AT THIS TIME**

Insurance Co. Name		Subscriber Name	
Insurance Tel. #		Subscriber Birth Date	
Insurance P.O. Box		Subscriber S.S. #	
Employer Name		Identification #	
Employer Tel. #		Group #	

Relationship to patient: ○Self ○Spouse ○Parent ○Guardian Subscriber Sex: ○Male ○Female

Marital Status: ○Single ○Married ○Divorced ○Other _____ Subscriber address same as patient's ○Yes ○No

Secondary Dental Insurance ☐ **I DO NOT HAVE SECONDARY DENTAL COVERAGE**

Insurance Co. Name		Subscriber Name	
Insurance Tel. #		Subscriber Birth Date	
Insurance P.O. Box		Subscriber S.S. #	
Employer Name		Identification #	
Employer Tel. #		Group #	

Relationship to patient: ○Self ○Spouse ○Parent ○Guardian Subscriber Sex: ○Male ○Female

Marital Status: ○Single ○Married ○Divorced ○Other _____ Subscriber address same as patient's ○Yes ○No

Subscriber's address if different than patient's:_____

****STOP** COMPLETE MEDICAL SECTION ONLY IF YOUR VISIT IS MEDICAL IN NATURE**
(i.e. Oral Surgery, Related to Accident, Oral Pathology)

Primary Medical Insurance ☐ **I DO NOT HAVE MEDICAL COVERAGE AT THIS TIME**

Insurance Co. Name		Subscriber Name	
Insurance Tel. #		Subscriber Birth Date	
Insurance P.O. Box		Subscriber S.S. #	
Employer Name		Identification #	
Employer Tel. #		Group #	

Relationship to patient: ○Self ○Spouse ○Parent ○Guardian Subscriber Sex: ○Male ○Female

Marital Status: ○Single ○Married ○Divorced ○Other _____ Subscriber address same as patient's ○Yes ○No

Secondary Medical Insurance ☐ **I DO NOT HAVE SECONDARY MEDICAL COVERAGE**

Insurance Co. Name		Subscriber Name	
Insurance Tel. #		Subscriber Birth Date	
Insurance P.O. Box		Subscriber S.S. #	
Employer Name		Identification #	
Employer Tel. #		Group #	

Relationship to patient: ○Self ○Spouse ○Parent ○Guardian Subscriber Sex: ○Male ○Female

Marital Status: ○Single ○Married ○Divorced ○Other _____ Subscriber address same as patient's ○Yes ○No

Subscriber's address if different than patient's:_____

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Dental Faculty Practice
Adult Medical History

Patient Name: _____ Date of Birth _____ Today's Date _____

Last *First* *M.I.*

PLEASE SELECT THE CORRECT ANSWER

Y	N	GENERAL
		HEIGHT _____ FT _____ IN
		WEIGHT _____ LBS
		GENERAL HEALTH STATUS (CHOOSE ONE): ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR
☐	☐	ARE YOU UNDER PHYSICIAN'S CARE?
☐	☐	HAVE YOU BEEN HOSPITALIZED IN THE PAST 10 YEARS?
☐	☐	HAVE YOU HAD ANY EMERGENCY ROOM VISITS IN THE PAST 10 YEARS?
☐	☐	HAS YOUR DOCTOR LIMITED YOUR ACTIVITY?
☐	☐	CAN YOU CLIMB TWO FLIGHTS OF STAIRS WITHOUT REST?

PLEASE ANSWER "YES" OR "NO" FOR ANY CONDITIONS THAT YOU HAVE NOW, OR HAVE HAD IN THE PAST

Y	N	CARDIOVASCULAR / HEMATOLOGIC
☐	☐	DO YOU HAVE ANY HEART, CIRCULATORY OR BLOOD PRESSURE CONDITIONS?
☐	☐	HEART ATTACK (MI)
☐	☐	CONGESTIVE HEART FAILURE (CHF)
☐	☐	ANGINA (CHEST PAIN)
☐	☐	HEART SURGERY / STENT / VALVE REPLACEMENT
☐	☐	HYPERTENSION (HIGH BLOOD PRESSURE)
		IF YES, WHAT IS YOUR USUAL BLOOD PRESSURE? _____
☐	☐	ARRHYTHMIA
☐	☐	PACEMAKER/ICD
☐	☐	OTHER HEART CONDITIONS: _____

Y	N	PULMONARY
☐	☐	DO YOU HAVE ANY LUNG OR BREATHING CONDITIONS?
☐	☐	ASTHMA
☐	☐	CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)
☐	☐	OTHER LUNG OR BREATHING CONDITIONS: _____

Y	N	NERVOUS SYSTEM
☐	☐	DO YOU HAVE ANY NERVOUS SYSTEM CONDITIONS?
☐	☐	SEIZURES - **IF YES**, PLEASE CHOOSE WHICH TYPE: ☐ ABSENCE ☐ GRAND MAL ☐ PETIT MAL ☐ OTHER
☐	☐	STROKE/TIA - **IF YES**, PLEASE CHOOSE WHICH TYPE: ☐ HEMORRHAGIC ☐ OCCLUSIVE
☐	☐	SYNCOP (FAINTING)
☐	☐	OTHER NEUROLOGICAL (NERVE) CONDITIONS? _____

Y	N	GASTROINTESTINAL / LIVER / BLOOD / METABOLIC
☐	☐	DO YOU HAVE ANY GASTROINTESTINAL, LIVER, BLOOD OR METABOLIC CONDITIONS?
☐	☐	HEPATIC (LIVER) DISEASE
☐	☐	HEPATITIS
☐	☐	RENAL (KIDNEY) DISEASE
☐	☐	UNUSUAL BLEEDING
☐	☐	SICKLE CELL ANEMIA / TRAIT
☐	☐	DIABETES - **IF YES**, PLEASE CHOOSE WHICH TYPE: ☐ I ☐ II
☐	☐	GASTROINTESTINAL (G.I.) DISEASE OR CONDITION
☐	☐	THYROID DISEASE

Y	N	INFECTIOUS DISEASES
☐	☐	DO YOU HAVE ANY INFECTIOUS DISEASES?
☐	☐	TUBERCULOSIS (TB)
☐	☐	HIV / AIDS - VIRAL LOAD _____ CD4 COUNT _____
☐	☐	HEPATITIS B
☐	☐	OTHER INFECTIOUS OR IMMUNE CONDITIONS: _____

Y	N	ORTHOPEDIC / MUSCULOSKELETAL
☐	☐	DO YOU HAVE ANY ORTHOPEDIC OR MUSCULOSKELETAL DISEASE?
☐	☐	BONE PROBLEMS OR DISEASES (OSTEOPOROSIS, OTHERS)
☐	☐	ARTIFICIAL JOINTS
☐	☐	ARTHRITIS - **IF YES**, PLEASE CHOOSE WHICH TYPE: ☐ OSTEOARTHRITIS ☐ RHEUMATOID ARTHRITIS ☐ OTHER
☐	☐	MUSCLE PROBLEMS OR DISEASES _____
☐	☐	JAW OR JAW JOINT PROBLEMS (TMD)

Y	N	OTHER
☐	☐	DO YOU HAVE ANY OTHER MEDICAL CONDITIONS?
☐	☐	PREGNANT OR NURSING IF PREGNANT, EXPECTED DELIVERY DATE _____
☐	☐	CANCER AND CANCER TREATMENT **IF YES**, WHAT TYPE/LOCATION _____
☐	☐	EMOTIONAL/PSYCHIATRIC DISORDERS _____
☐	☐	FREQUENT SINUS INFECTIONS (SINUSITIS)
☐	☐	SLEEP APNEA
☐	☐	DO YOU HAVE THE SYMPTOMS BELOW? ☐ SNORE LOUDLY ☐ OFTEN TIRED, FATIGUED, OR SLEEPY ☐ OBSERVED TO STOP BREATHING OR CHOKE/GASP IN YOUR SLEEP ☐ BEING TREATED FOR HIGH BLOOD PRESSURE ☐ NECK SIZE (SHIRT COLLAR) OVER 17" (MEN) OR 16" (WOMEN)

Y	N	SOCIAL
☐	☐	HAVE YOU EVER CONSUMED ALCOHOL OR USED RECREATIONAL DRUGS?
☐	☐	DO YOU CONSUME ALCOHOLIC BEVERAGES? **IF YES.....** HOW MANY TIMES IN THE PAST YEAR HAVE YOU HAD 4 (WOMEN), 5 (MEN) OR MORE DRINKS IN A SINGLE DAY? _____
☐	☐	DO YOU USE RECREATIONAL DRUGS?
☐	☐	HAVE YOU EVER SMOKED CIGARETTES? FOR HOW MANY YEARS? _____ HOW MANY PACKS PER DAY? _____
☐	☐	ARE YOU A FORMER SMOKER? **IF YES**, WHEN DID YOU QUIT? MONTH _____ YEAR _____
☐	☐	HAVE YOU EVER USED TOBACCO (OTHER THAN CIGARETTES)? **IF YES**, WHAT TYPE? _____
☐	☐	DO YOU USE ELECTRONIC CIGARETTES?
☐	☐	DO YOU HAVE PROBLEMS OR CONDITIONS NOT LISTED ABOVE? _____
☐	☐	DO YOU HAVE A CONDITION REQUIRING ACCOMMODATION? _____

MEDICATIONS AND ALLERGIES

LIST ANY CURRENT OR RECENT MEDICATIONS YOU TAKE:

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES OR REACTIONS TO ANY MEDICINES?

MEDICINE: _____

REACTION: _____

MEDICINE: _____

REACTION: _____

MEDICINE: _____

REACTION: _____

MEDICINE: _____

REACTION: _____

I certify that the above information is complete and accurate to the best of my knowledge. I understand that providing incomplete or inaccurate information may negatively influence my treatment and my treatment results.

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Dental Faculty Practice
Supplemental Medical History
for Surgery and Anesthesia

Patient Name: _____ Today's Date: _____
Last *First* *Middle Initial*

Date of Birth: _____

PLEASE ANSWER THESE QUESTIONS:

LIST TREATING PHYSICIANS AND DENTISTS - PLEASE INCLUDE YOUR PRIMARY CARE PHYSICIAN, DENTIST, AND ANY SPECIALISTS CARING FOR YOU

NAME: _____ SPECIALTY: _____

ADDRESS: _____ PHONE: _____

NAME: _____ SPECIALTY: _____

ADDRESS: _____ PHONE: _____

NAME: _____ SPECIALTY: _____

ADDRESS: _____ PHONE: _____

NAME: _____ SPECIALTY: _____

ADDRESS: _____ PHONE: _____

NAME: _____ SPECIALTY: _____

ADDRESS: _____ PHONE: _____

NAME: _____ SPECIALTY: _____

ADDRESS: _____ PHONE: _____

ADDITIONAL QUESTIONS FOR SURGERY AND ANESTHESIA

PAST SURGERY (please list operation and year):	YES	NO	**OFFICE USE ONLY**
_____			
_____			
PAST ANESTHETICS (please describe):	YES	NO	
_____			
PROBLEMS/COMPLICATIONS OF SURGERY OR ANESTHESIA (please describe):	YES	NO	
_____			
PROBLEMS WITH ANESTHESIA FOR **FAMILY MEMBERS** (relationship, describe):	YES	NO	
_____			

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CONSENT FOR INSURANCE RELEASE/AUTHORIZATION/ ASSIGNMENT AND FIANANCIAL RESPONSIBILITY

Patient Name: _____ **Date of Birth:** _____

Please Read Each Paragraph and Initial

Insurance Verification/Release/Authorization/Assignment

_____ I certify that the information pertaining to my active dental and/or medical insurance coverage is correct.

_____ I authorize the release of any dental/medical records or other information, including the diagnosis and treatment rendered to me, as requested by my dental and/or medical insurance carrier. I am aware this may include information regarding HIV or AIDS, alcohol or drug abuse and psychiatric treatment.

_____ I request and assign benefit payment(s) from my insurance carrier(s) directly to the Dental Faculty Practice and to the practitioner who rendered my service.

Financial Responsibility

_____ I understand that payment is expected in full prior to the services being rendered for patients who do not have dental or medical insurance (if applicable) coverage.

_____ I understand that should I arrive on the day of my appointment with no means of payment, the Dental Faculty Practice reserves the right to reschedule my appointment.

_____ Missed or Broken appointments (if less than 24 hours' notice) may have a fee assessed at the provider's discretion and this fee is the patient's responsibility.

Patients who have verified dental (and/or medical, if applicable) insurance benefits

_____ I understand that the financial obligation for any services rendered/received is my responsibility and not the responsibility of the Dental Faculty Practice, my provider of service or my insurance carrier. I understand that the Dental Faculty Practice will make reasonable effort on my behalf to obtain all applicable benefits from my insurance carrier(s), but there is no promise or guarantee of payment/coverage. Any balance due after insurance processing and/or insurance payment received is my responsibility. ***Note** Account balance is due 60 days from the date of service, whether payment has been received from your insurance carrier or not.*

_____ I understand that my Dental Faculty Practice provider may not be an "in-network" provider with my medical and/or dental insurance carrier and services/procedures may be subject to out-of-network deductibles, allowables and co-payments.

_____ Co-payment, deductible and deposit (in some cases) is payable prior to the services being rendered. A predetermination of dental benefits may be submitted (time permitting) prior to initiation of treatment in order to obtain the estimated patient out-of-pocket expense. If you would like a predetermination of dental benefits, please contact the insurance/financial department.

_____ Account balances must remain in good standing to avoid collection proceedings. Payment contracts/ arrangements must follow agreed upon guidelines. Past due account balances (90+ days) will be forwarded to our collection agency.

Payment Options

- Cash, check, MasterCard, Visa, Discover, American Express or debit cards are acceptable.
- H.S.A. (if applicable) and Flexible Spending benefit cards or checks are acceptable.
- Care Credit - For those patients who prefer to extend payments beyond the conclusion of treatment. We are pleased to offer Care Credit; the American Dental Association's approved commercial line of credit, specifically designed for the payment of dental care. To learn more about Care Credit, feel free to speak to the insurance/ financial department.

***NOTE** A NSF fee of $34 will be charged for returned checks*

****PLEASE NOTE**** - **Divorced Parents**: ***The parent who is present with the patient at time of appointment will be considered the "financially responsible party" and will be accountable for all fees incurred.***

_____ **MEDICAID PATIENTS** I understand I must submit my current Medicaid identification card on the day service is rendered. I also understand after Medicaid has processed the claim there may be a portion of the balance which will be my responsibility. I agree to pay this balance within 30 days.

_____ **MEDICARE PATIENTS** I understand that Medicare rarely covers dental procedures and I am responsible for the full fee associated with such services. I understand that after Medicare processes my claim, any balance due is my responsibility. I agree to pay this balance within 30 days.

_____ **BWC/TRAUMA/ACCIDENT PATIENTS** I understand that it is my responsibility to notify the insurance department that I am being treated as a result of an injury **prior to** any services being performed. A treatment coordinator from the insurance/financial department will be assigned to my case to work with me in regard to insurance/financial matters.

FINANCIAL RESPONSIBILITY / *WHO WILL BE RESPONSIBLE FOR THIS ACCOUNT?*

___ **PATIENT IS RESPONSIBLE PARTY**

RESPONSIBLE PARTY INFORMATION (Complete if patient is not Responsible Party)

NAME _____ **RELATIONSHIP** ___ **Spouse** ___ **Parent** ___ **Other**

DATE OF BIRTH _____ **SOCIAL SECURITY #** _____

HOME PHONE _____ **CELL PHONE** _____

HOME ADDRESS _____
STREET

_____
CITY **STATE** **ZIP**

EMPLOYER _____ **PHONE** _____

ALTERNATE CONTACT (CLOSEST RELATIVE WHO DOES NOT LIVE WITH YOU)

_____
NAME **RELATIONSHIP** **PHONE #**

By signing below I verify that I have read, understand and accept the guidelines and terms stated within the Dental Faculty Practice Initial Consent for Treatment, Insurance Release/Authorization/Assignment and Financial Responsibility form and that I am the financially responsible party for this patient's account.

_____ _____
Print Name of Responsible Party **Signature**

_____
Date

Patient Name: _____

Record #: _____

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at The Ohio State University

General Consent for Dental Treatment

Patients, patient representatives, parents and guardians please read this form carefully

I give my consent for examination and treatment at The Ohio State University, Dental Faculty Practice. I understand that I may withdraw consent and refuse treatment at any time before the treatment is provided. This treatment may include, but is not limited to, the following:

1. Examination of the tissues of the mouth (including the teeth, tongue, throat, cheeks, probing of the gums, etc.);
2. X-rays;
3. Numbing the tooth, teeth, or gums;
4. Cleaning the teeth and other gum-related treatment; and,
5. Blood studies for infections (like HIV/AIDS, hepatitis, etc.) as needed for health worker safety (for example: needle stick, etc.).

I understand the following:

1. I may experience some problems during examination and treatment that my dentist cannot predict. These include but are not limited to:
   - pain, discomfort, or swelling lasting several days
   - Infection and bleeding
   - injury to other nearby teeth, fillings, crowns, lips and gums
   - short-term, long-term or permanent numbness of the teeth, gums, tongue, cheek, lip or chin
   - unplanned reaction to a drug, dental material, latex, etc.
   - jaw joint (TMJ) problems
   - breathing in or swallowing a dental instrument or dental material
   - unplanned reaction to local anesthesia
   - any complication may result in additional treatment
2. All records including x-rays, photos (including full face), recordings and drawings will remain the sole property of The Ohio State University Dental Faculty Practice. These records may be used for teaching and publication.
3. There is no guarantee of treatment results.
4. It is my responsibility to follow the post-treatment protocols of the Dental Faculty Practice.
5. Emergency treatment (for example: extractions) is ***not*** complete dental care. I understand that it is my responsibility to seek more dental care, after receiving emergency treatment, as recommended.

I am, or my parent, legal guardian or representative is, signing this consent. I was given the opportunity to ask questions about these risks. All of my questions were answered. I understand and give my consent for dental examinations, tests, and dental treatment.

Please Print Patient's Name _____

Patient/Parent/Legal Guardian/ Representative Signature _____ **Date** _____

The patient is responsible for the cost of follow-up care.
The cost of more treatment is not included in the original cost estimate.

THE OHIO STATE UNIVERSITY
COLLEGE OF DENTISTRY

ORAL AND MAXILLOFACIAL SURGERY
INITIAL CONSENT, INSURANCE RELEASE, AND PERMISSION TO TREAT

Cancellation Policy

Appointments cancelled with less than 48 business hours notice are considered broken appointments. For consultations, the patient may be dismissed from the care of the Division of Oral and Maxillofacial Surgery after two (2) broken appointments. For surgery appointments, the patient may be dismissed from the care of the Division of Oral and Maxillofacial Surgery after one (1) broken appointment.

I have read and fully understand this document and have had any questions answered to my satisfaction.

Patient/Parent or Guardian Date

Person Responsible for Bill (if other than patient) Date

dentalfacultypractice
at The Ohio State University

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means. This would include mailing correspondence to the individual's office instead of the individual's home, emailing correspondence (via secure email server) and/or the use of text messaging systems.

I wish to be contacted in the following manner (*check all that apply*):

Home Phone (_____) _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with callback number only

Cell Phone (_____) _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with callback number only
- ☐ O.K. to text appointment information
- ☐ O.K. to text account/financial information

Work Phone (_____) _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with callback number only

Written Communication - U.S. Mail/Fax

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to number indicated below

Fax # (_____) _____

Written Communication - E-mail (via secure email server)

- ☐ O.K. to email appointment information
- ☐ O.K. to email account/financial information

Email Address:

_____

I hereby grant permission for Dental Faculty Practice providers and/or representatives to share clinical and financial information with or answer questions from (*check all that apply and print name or names*):

- ☐ Spouse _____
- ☐ Parent _____
- ☐ Child _____
- ☐ Other (name and specify relationship): _____
- ☐ Direct patient contact only

_____
Patient or Guardian Signature

_____
Print Name of Patient or Guardian

_____
Date Signed