DR. LARRY SCHOONOVER

P.O. Box 672 1 French Street
Clendenin, WV 25045
(304) 548-7227

REGISTRATION AND CONSENT FORM

A. General Information

Name: _____ Social Security No.: _____
First Middle Last

Nickname/Preferred Name: _____

Birthdate: _____ Sex: _____ Marital Status: _____

Address: _____
Street or Box City State Zip

Telephone: Home: _____ Work: _____

Occupation: _____ Employer/School: _____

Referred by: _____ Yellow Pages _____ Advertisement _____

E-Mail:

B. Responsible Party for Payment

Name: _____ Social Security No.: _____
First Middle Last

Employer: _____

Work Address: _____ Work Phone _____
Street or Box

_____
City State Zip

Primary Insurance Company

Name: _____

Insured's Name: _____

Employer Providing Ins.: _____

Policy/Certificate No.: _____

Secondary Insurance Company

Name: _____

Insured's Name: _____

Employer Providing Ins.: _____

Policy/Certificate No.: _____

C. Person to be contacted in case of emergency

Name: _____ Relationship to Patient: _____

Address: _____ Telephone: _____

D. Consent

I, the undersigned, voluntarily consent to the receipt of routine dental care from Dr. Schoonover, a general dentist, and his authorized staff. This may include X-rays, study models, photographs, or other diagnostic aids to make a thorough diagnosis of dental needs, in addition to any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic (numbing) agents incurs a certain risk. Certain risks of anesthesia and/or dental treatment may include, but are not limited to, pain, swelling, bleeding or bruising, damage to adjacent teeth, fillings or crowns; temporary or permanent lip or tongue numbness, sinus entry and/or problems, soreness at injection site, allergic reaction to any drugs or medication and/or infection.

I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatment or examination by Dr. Schoonover and his staff.

I hereby authorize my insurance benefits be paid directly to Dr. Schoonover. I also authorize the release of any information required by third parties to obtain payment for services rendered. I am financially responsible for all services rendered. I further understand that a one and one-half percent finance charge (18 percent annually) will be added to any balance over 60 days.

Patient Signature _____ Date _____

Parent or Responsible Party _____

Relationship to Patient _____

Witness _____

PRESENT DENTAL CONDITION

I brush (how often)_____ I floss (how often)_____

Please check all that apply to you:

_____ I am in pain.
_____ I am swollen.
_____ I have decay.
_____ I clench or grind my teeth.
_____ I have a broken filling.
_____ I have gum problems.

_____ I am proud of my smile.
if not, why?
_____ Crooked teeth.
_____ Missing teeth.
_____ Dark teeth.
_____ Bad teeth.
_____ Dark fillings.
Other:_____

FUTURE PLANS

Please check items that apply to you:

_____ I am interested in a preventive dental care program with regular exams and cleaning every 6 months.
_____ I want to keep my teeth as long as I can.
_____ I want extractions and dentures.
_____ I want some missing teeth replaced.
_____ I want straighter teeth.
_____ I want whiter teeth.
_____ I want only relief of pain.
_____ I want _____
_____

Request Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and your reasoning that supports your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

- the information was not created by us, or the person who created it is no longer available to make the amendment;
- the information is not part of the record which you are permitted to inspect and copy;
- the information is not part of the designated record set kept by this practice; or if it is the opinion of the health care provider that
- the information is accurate and complete.

Request Restrictions. You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations. *For example* – you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our practice manager.

We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your request unless that information is needed for emergency treatment.

An Accounting of Disclosures. You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) nor for a period of time greater than six years (our legal obligation to retain information).

Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. *For example* – you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

File a Complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice manager or directly to the Secretary of Health and Human Services.

To file a complaint with our manager, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to Lawrence H. Schoonover, D.D.S., #1 French Street, P.O. Box 672, Clendenin, WV 25405. You should know that there would be no retaliation for your filing a complaint.

Uses or Disclosures Not Covered

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

For More Information

If you have questions or would like additional information, you may contact our practice manager at 304-548-7227.

Effective Date: 04/14/03

NOTICE OF PRIVACY PRACTICES

LAWRENCE H. SCHOONOVER, D.D.S.

#1 FRENCH STREET
PO BOX 672
CLENDENIN, WV 25405

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

In accordance with the Health Insurance Portability and Accountability Act we are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

Ways in Which We May Use and Disclose Your Protected Health Information:

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician who we have requested to be involved in your care. *For example* – we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Payment. We will use and disclose your protected health information to obtain payment for the health care services we provide you. *For example* – we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations. We will use and disclose your protected health information to support the business activities of our practice. *For example* – we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription services for our practice.

Other Ways We May Use and Disclose Your Protected Health Information:

Appointment Reminders. We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.

Treatment Alternatives. We will use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

Others Involved in Your Care. We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

Research. We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

As Required by Law. We will use and disclose your protected health information when required to by federal, state, or local law. You will be notified of any such disclosures.

To Avert a Serious Threat to Public Health or Safety. We will use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Worker's Compensation. We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates. We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

A Paper Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy. You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our practice manager, Lawrence H. Schoonover, D.D.S., #1 French Street, P.O. Box 672, Clendenin, WV 25405. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

Lawrence H. Schoonover, D.D.S.

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

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please Specify)

_____

_____

_____

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____

BIRTHDATE _____ SOCIAL SECURITY # _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations - and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

☐ **I request the following restrictions to the use or disclosure of my health information:**

_____

_____

_____

PATIENT:

X_____ _____ _____

Signature of Patient or Legal Representative | Date | Witness Signature

OFFICE USE ONLY:

☐ Accepted

☐ Denied

_____ _____ _____

Signature | Title | Date

LAWRENCE H. SCHOONOVER, D.D.S.
P.O. Box 672 1 French St.
Clendenin, WV 25045
Phone 548-7227 965-7007

Name _____ Birthplace _____

Age_____ Sex_____ Height_____ Weight_____ Marital Status_____ Occupation_____ Race_____

Physician, address, and phone _____

Date of last physical examination _____ Reason_____ Findings_____

Are you presently being treated by a physician?_____ Reason_____

Are you presently taking any medicine, pills, drugs?_____ Reason _____

Radiation History M & D _____

Chief Complaint _____

Date To the best of your knowledge, have you ever had or have you now: (Please check at left each item)

Yes	No	(Check Each Item)	Yes	No	(Check Each Item)	Yes	No	(Check Each Item)
		CARDIOVASCULAR SYSTEM			Chronic cough, hoarseness, or sore throat			**BONES AND JOINTS**
		Heart trouble or heart murmurs +			Tobacco, snuff, or alcohol habit			Arthritis or rheumatism
		Pain or pressure in chest			**GASTROINTESTINAL SYSTEM**			Frequent fractures or dislocations
		Rheumatic fever or growing pains +			Stomach or intestinal trouble			A condition requiring cortisone therapy +
		Swollen or painful joints			Frequent indigestion, diarrhea, or vomiting problems			**SPECIAL ORGANS**
		Soaking sweats with prolonged fever			Appetite problem or difficulty in swallowing			Ear, eye, nose or throat trouble
		High or low blood pressure +			Jaundice, hepatitis +			Sinusitis or headaches
		Shortness of breath			Liver trouble, gall bladder trouble or stones			Facial injuries or toothaches
		Frequent nose bleeds			**GENITOURINARY SYSTEM**			**OTHERS**
		Problems associated with a stroke			Kidney disease or a problem of frequent urination			Tumors, growths, cysts or cancers +
		ENDOCRINE SYSTEM			Swollen ankles or eye lids			Recent gain or loss of weight
		Gland problem, goiter, or thyroid condition			**NERVOUS SYSTEM**			Scarlet fever, pneumonia, mumps, or any high fever disease
		Diabetes (sugar or albumin in urine +			Nervous or mental disorders			A reaction to serums, drugs or medicines +
		Dry or burning mouth			Epilepsy or convulsions +			Any reaction to penicillin, antibiotics or dental anesthetics +
		Members of your family with diabetes or tuberculosis +			Neuritis, neuralgia or numbness			Series of needles, shots or injections
		RESPIRATORY SYSTEM			**BLOOD**			Major operations or hospitalization
		Respiratory disease			Blood diseases			Pregnancy or menstrual problems
		Continuous stuffy nose			Dizziness or fainting spells Anemia			Skin rash, hives, or other skin problems
		Asthma, hayfever, or allergies +			Bleeding gums			Venereal disease or any other conditions we should be aware of +
		Tuberculosis A halitosis problem			Excess bleeding following a scratch, cut or tooth extraction +			AIDS Risk +

MEDICAL CONSULTATION

NAMES OF FAMILY MEMBERS

LAWRENCE H. SCHOONOVER, D.D.S.
P.O. Box 672 1 French St.
Clendenin, WV 25045
Phone 548-7227 965-7007

DATE:

DISCUSSION:

DENTAL HISTORY: (Investigate the following items)

1. Regularity of dental visits
2. Regularity of oral prophylaxis
3. Previous gum treatment
4. Previous orthodontic treatment
5. Previous extractions
6. Previous root canal therapy
7. Reasons for teeth loss
8. Dental appliances worn by patient
9. Oral habits
10. Hereditary dental factors
11. Dietary aspects of oral health
12. Unusual dental experience

Comments:

Completed by: _____

Lawrence H. Schoonover, D.D.S.
P.O. Box 672 1 French St.
Clendenin, WV 25045
Phone 548-7227 965-7007

PEDIATRIC DENTISTRY

NAME _____

CASE HISTORY

CHART NO. _____

Health

	Yes	No
1. Is your child being treated by your physician presently?	( )	( )
2. Has your child ever been a patient in a hospital?	( )	( )
3. Has your child ever been a patient in an emergency room?	( )	( )
4. Does your child have any allergies?	( )	( )
5. Is your child presently taking any medicines?	( )	( )
6. Does your child require immunizations presently to be protected against:		
Diphtheria, Whooping Cough and Tetanus	( )	( )
Polio	( )	( )
Measles and German Measles (Rubella)	( )	( )
7. Has your child had any difficulty in school?	( )	( )

8. Place a check if your child or any member of your family has (or had) problems with the following:

Heart	( )	Diabetes	( )	Rheumatic fever	( )	Emotions	( )
Kidney	( )	Asthma	( )	Bleeding	( )	Other	( )
Liver	( )	Epilepsy	( )	Speech	( )		

Dental

	Yes	No
9. Has your child ever been seen by a dentist?	( )	( )
10. Will your child be an uncooperative dental patient?	( )	( )
11. Does any member of your family object to visiting the dentist?	( )	( )
12. Has your child inherited any family dental characteristic?	( )	( )
13. Does your child suck his fingers or thumb or have a similar habit?	( )	( )

14. Please check if your child has (or had):

Toothache	( )	Teeth bumped	( )	Bleeding gums	( )
Sensitive Teeth	( )	Discolored Teeth	( )	Other	( )

	Yes	No
15. Is your community water supply fluoridated?	( )	( )
16. Have you ever given your child fluoride vitamins or tablets?	( )	( )
17. Do you supervise your child's cleaning procedures?	( )	( )
18. Does your child use dental floss?	( )	( )

19. How often does your child clean his teeth? _____

20. What type toothpaste does he use? _____

Is there additional information we should be aware of prior to providing dental care for your child?_____

_____

Comments: (All positive and/or significant responses must be elaborated by dentist)

. . . . . .

. . . . . .

. . . . . .

. . . . . .

Dentist _____
(Name) (Number)

LAWRENCE H. SCHOONOVER, D.D.S.
P.O. Box 672 1 French St.
Clendenin, WV 25045
Phone 548-7227 965-7007

DATE: _____
DISCUSSION:

DENTAL HISTORY: (Investigate the following items) **Comments:**

1. Regularity of dental visits
2. Regularity of oral prophylaxis
3. Previous gum treatment
4. Previous orthodontic treatment
5. Previous extractions
6. Previous root canal therapy
7. Reasons for teeth lost
8. Dental appliances worn by patient
9. Oral habits
10. Hereditary dental factors
11. Dietary aspects of oral health
12. Unusual dental experience

Completed by:_____

LARRY SCHOONOVER, DDS, MAGD
Master, Academy of General Dentistry

2 locations: 1 French Street, Clendenin, WV
201 Main Street, Elkins, WV

Mailing address: P. O. Box 672, Clendenin, WV 25045

304 548 7227 1 888 has-smiles 1 888 427-7645
www.has-smiles.com

PHOTOGRAPHIC CONSENT

I, the undersigned, do hereby give my permission for Dr. Larry Schoonover and/or his employees to take photographs, x-rays, and impressions of me and/or my child.

I further permit Dr. Schoonover to use any previous, present, or future photographs, x-rays, or models of my or my child's likeness for education, demonstration, display, or publication through any media, including print and/or electronic.

I have had the opportunity to discuss this consent with Dr. Schoonover, and he has satisfactorily informed me and answered all my questions.

Patient Name (please print):
_____

Responsible Parent (please print):_____

Signature:_____

Date: _____

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