



Please complete and return all completed forms
Once returned, we will call to schedule.

In continuation of providing the highest quality care for our patients, the Nisonger Center Dental Program requires updated forms prior to any and all treatment.

We will reschedule anyone who does not bring required forms.

Forms **MUST** be signed by the legal guardian. If the patient is not their own guardian, we must have proof of legal guardianship.

We require the following forms:

1. Patient Registration Form; page 2
2. Medical Health History Form; page 3
3. Medication List; page 4 - or a copy of medication list/MAR
4. Behavior History Questionnaire; pages 5-7
5. Treatment Consent Form; page 8
6. HIPPA Form; page 9
7. Broken Appointment Policy; page 10
8. Behavior Management Consent; pages 11-13
9. Research Registry; page 14
10. Copy Insurance Card(s)
11. Guardianship Form - from Probate Court if patient is not their own

guardian

*** * * PLEASE NOTE: WE ARE NOT LOCATED AT THE OSU
COLLEGE OF DENTISTRY!!!! * * ***



PATIENT REGISTRATION

First Name: _____ Last Name: _____ MI: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Live in a Care Facility? ☐ Yes ☐ No Facility Name: _____

Date of Birth: _____ Social Security #: _____

Driver's License: _____ E-Mail Address: _____

Employed: ☐ Yes ☐ No Employer Name: _____ Phone: _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Other

Ethnicity: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ American Indian ☐ Native Hawaiian

☐ Prefer not to answer

Is the patient their own legal guardian? ☐ Yes ☐ No

If not, please supply proof of legal guardianship with court documentation.

Does the patient receive services from the County Board of Developmental Disabilities?

☐ Yes ☐ No Which county? _____

Is the patient the responsible party? ☐ Yes ☐ No

Responsible Party: _____ Address: _____

Relationship: _____ Phone: _____

Responsible Party DOB: _____ SS#: _____

Emergency Contact: _____ Phone: _____

Relationship to Contact: ☐ Spouse ☐ Live-In ☐ Parent ☐ Other _____

Referring or Previous Dentist and Phone: _____ Date Last Seen: _____

Were x-rays taken at the previous office? ☐ Yes ☐ No (if yes, please contact the office to have x-rays taken within 3-5 years sent to our office via email: NisongerDental@osumc.edu)

PRIMARY INSURANCE (Please provide a copy of the Insurance, Medicaid or Medicare Card to us.)

Same as Patient ☐ Same as Guarantor ☐ Other

Insured Party: _____

Insured Phone: _____

Insurance Company: _____

Insurance Group #: _____

Relationship to Primary Insured/Guarantor:

Self ☐ Other

Social Security #: _____

Date of Birth: _____

ID #: _____

SECONDARY INSURANCE

Same as Patient ☐ Same as Guarantor ☐ Other

Insured Party: _____

Insured Phone: _____

Insurance Company: _____

Insurance Group #: _____

Relationship to Primary Insured/Guarantor:

Self ☐ Other

Social Security #: _____

Date of Birth: _____

ID #: _____

Printed Name: _____

(Of court appointed guardian if patient is not their own)

Signature: _____ Date: _____

(Signed by court appointed guardian if patient is not their own)



Health History

Patient name: _____

Date: _____

Does the patient currently have or have had any history of the following:

Alcohol Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina/Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV or AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertension (↑BP)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hyperthyroidism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypothyroidism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Intellectual Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autism Spectrum Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bipolar	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cerebral Palsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurodevelopmental Diagnosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neuropathy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cirrhosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Defect	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congestive Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No
COPD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coronary Artery Bypass Graft	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Self-Injurious Behavior (SIB)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Anemia or Trait	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech Difficulties	<input type="checkbox"/> Yes <input type="checkbox"/> No
Genetic Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	STD	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
G-Tube	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco Use	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Traumatic Brain Injury (TBI)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other: _____			

Hospitalization with any serious illness? ☐ Yes ☐ No - Reason/Date: _____

Are you allergic to any medications? Reaction? _____

Are you taking any prescription medications? ☐ Yes ☐ No (Please complete the medication list on next page or supply a separate medication list)

Are you currently under the care of a Physician?
Physician: _____

☐ Yes ☐ No
Phone Number: _____

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (patient's) health. It is my responsibility to inform the dental office of any changes in medical status

Signature: _____
(Signed by court appointed guardian if patient is not their own)



MEDICATION LIST



Patient Name: _____

Date: _____

Neurobehavioral History

Communication and Behavior

Is the patient able to communicate verbally? ☐ Yes ☐ No
Are there certain cues that might help the dental team?

Are there any useful phrases or words that work best for the patient?

Does the patient use non-verbal/augmentative communication? ☐ Yes ☐ No
Please check any of the following that the patient uses:

- ☐ Picture Symbols Type: _____
- ☐ Picture Exchange Communication System
- ☐ Sign Language
- ☐ Electronic Device

Can you bring the communication system with you? ☐ Yes ☐ No
What symbol/signs can we provide to assist with communication?

Are there any objects that would be comforting for the patient or that would make the visit more pleasurable? (Feel free to bring them)

Does the patient have any favorite music? _____

Are there any rewards or reinforcements that work well for the patient? _____



Behavior and Emotions

Please list any specific behavior challenges that you would like the dental team to be aware of:

Sensory Issues

Please list any sensitivities the patient may have to:

Sound: _____

Vision: _____

Is the patient more comfortable in a dimly lit room? ☐ Yes ☐ No

Kinesthetic and Movement: _____

Taste: _____

Smell: _____

Touch: _____

Does the patient have any specific oral sensitivities? If yes please explain _____

Is the patient more comfortable in a clutter-free environment? ☐ Yes ☐ No
Does the patient prefer quiet? ☐ Yes ☐ No

Form completed by: _____

Relationship to the patient: _____

We want the appointment to go as smoothly as possible. If there is anything you would like to discuss in additional detail before the appointment, please call (614) 685-3197. Thank you!



Social and Behavior History

Will patient cooperate for dental treatment?

☐ Yes ☐ No

Has there been a bad dental experience?

☐ Yes ☐ No

What helps this person have a safe, enjoyable dental appointment?

When afraid or anxious, how does this person usually respond?

Does this person require general sedation or has had general sedation in the past for dental services?

☐ Yes ☐ No

Relationship to the patient:

- ☐ Self
- ☐ Parent
- ☐ Care Coordinator/Home Manager
- ☐ Staff/Care Provider
- ☐ Nurse

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (patient's) health. It is my responsibility to inform the dental office of any changes in medical status/

Signature: _____
(Signed by court appointed guardian if patient is not their own)



CONSENT FOR TREATMENT

Consent is hereby granted to the professional staff, students, residents and other health consultants of The Nisonger Center Dental Program, not limited to but includes diagnosing and treating the oral health needs of:

Print Patient's Name

_____ Permission is also given to The Nisonger Dental Program to furnish any insurance company obligated to them or to the patient or any welfare or relief organization or any governmental subdivision to which they have applied or may apply for aid to the patient, any and all pertinent information with respect to any illness or injury, medical history, consultation, treatment or copies of any with respects to the patient, as required.

_____ It is expressly understood and agreed that by signing below as the parent/individual of legal guardian, I am financially responsible for the above referenced patient and the patient's account.

_____ A patient that requires treatment beyond the scope of our practice will be issued a referral. In the best interest of our patients, sedation and/or behavior management beyond what is available at Nisonger Dental Program will require a referral to a non-specialty clinic. Once referred, that will become the permanent dental home.

Date

(Signed by court appointed guardian if patient is not their own)

Relationship



IMPORTANT NOTICE REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Your privacy is important to us. We are committed to protecting your health information. This notice applies to all the records of your care generated by this health care practice. This Notice of Privacy Practices describes your rights with regards to your health information, how we may use your health information and how we must protect the confidentiality of your health information.

This notice is a summary of the more detailed information contained in our Notice of Privacy Practices.

YOUR RIGHTS INCLUDE:

- A right to request restrictions on what information we use or how we disclose your protected health information
- A right to request confidential communications
- A right to review and obtain a copy of your protected health information
- A right to amend your protected health information
- A right to request and account of disclosures we have made with your protected health information
- A right to receive a paper copy of our Notice of Privacy Practices

WE ARE REQUIRED BY LAW TO:

- Make sure that your protected health information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to your protected health information
- Notify you upon a breach of your protected health information
- Follow the terms of the notice that is currently in effect

WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

- | | |
|-------------------------------|---|
| • For Treatment | • Health Oversight Activities |
| • For Payment | • Law Enforcement |
| • For Health Care Operations | • Lawsuits and Disputes |
| • As Required By Law | • Coroners, Health Examiners, and Funeral Directors |
| • For Health-related research | • To Avert a Serious Threat to Health or Safety |
| • Public Health Risks | |

The Ohio State University Nisonger Center is an academic and research institution. Researchers who are working to find new treatments and cures or important information to improve your health care and the health care if the general public may use or access your information. We may share your information to assist in the training and education of our health care professionals. Every person who may access your information is bound by our confidentiality requirements as outlined in our Notice of Privacy Practices.

We encourage you to carefully read this Notice of Privacy Practices. You may also access our Notice of Privacy Practices on our website: <http://nisonger.osu.edu>. Your health care provider may provide you with an additional notice regarding his/her office's Privacy Practices.

I received the Notice of Privacy for The Ohio State University Nisonger Center:

Print Name: _____

Date: _____

(Signed by court appointed guardian if patient is not their own)

Relationship to Patient



LATE AND BROKEN APPOINTMENT POLICY
***UPDATED 2021**

Because of the overwhelming demand for dental appointments at Nisonger Dental Program, we have found it necessary to adopt the following policy regarding late and broken appointments. This is intended to assure that valuable appointments are used as effectively as possible.

Arrival time for all appointments is 15 minutes prior to scheduled appointment time for registration.

If a patient presents to the office 10 minutes late for a scheduled appointment with our providers, the patient will be asked to reschedule their appointment.

Patients with three broken appointments within a twelve month period will be eligible for emergency care only for a period of one year after the third broken appointment. An appointment is considered broken if the patient: (1) does not show up for the appointment, (2) arrives more than 15 minutes late, (3) cancels the appointment with less than 24 hours notice, or (4) does not bring the required paperwork to the appointment.

After one year, the patient may request reinstatement for routine care once again.

(Signed by court appointed guardian if patient is not their own)

Relationship

Date



Informed Consent for Behavior Management Performed by Nisonger Dental Program

Other dentists, resident dentists or dental trainees may be involved with provision of care.

Patients and Legal Guardians please read this form carefully

For the patient I, or the Legal Guardian, agree to the behavior management plan as discussed prior to the start of treatment. I understand that consent can be withdrawn and I can refuse treatment at any time before the treatment is provided. I also realize that the behavior management recommendations may change.

I understand the following:

1. We want to give the patient excellent and safe care. This can be difficult or impossible, because some the patients cannot hold still or understand directions. Some behaviors can make it hard to deliver safe dental care. These are: hyperactivity, not opening the mouth, head shaking, kicking, screaming, biting, and grabbing the dentist's hands or dental tools.
2. All efforts are made to help the patient through the treatment with kindness, friendliness, coaching, humor, gentleness, listening and understanding.
3. Several ways can be used to help the patient cooperate. These will decrease disruptive behavior and/or prevent patients from causing injury to themselves and/or the dental staff. How we proceed will depend on what is best for the patient and acceptable to you. We also consider if there is an emergency or if the treatment can be delayed until the patient can help and understand. We will make these decisions together. Here are ways we use to help the patient have a safe and good appointment:
 - **Tell-Show-Do:** The dentist or assistant tells the patient what is to be done using simple words. Then, the patient will see the dental tool and how it will be used in the mouth. Then the treatment is done in the patient's mouth. Praise and kind words are used to help the patient through the treatment.
 - **Positive reinforcement:** This approach rewards the patient who shows helpful and brave behavior during the appointment. Rewards include praise, a smile, a pat on the back, or a prize.
 - **Distraction:** This approach directs the patient's attention away from what is being done in the treatment.
 - **Voice control:** If the patient is not behaving well, the level of the dentist's, assistant's, and/or student's voice changes. They also use short and clear sentences. A kind but firm voice helps the patient understand the rules. Praise comes as soon as the patient listens.



- **Nitrous oxide/oxygen inhalation (laughing gas):** Laughing gas is a safe and effective drug to help the patient relax. This way they are more willing to accept care and listen to the dentist. Sometimes the patient will feel like they are floating and will start to giggle or laugh. Some patients' may fall asleep. Some patients' will have a ring shaped mark on their nose where they breathe in the gas. This mark will go away in a short time. Some patients' will get sick to their stomach, especially if they have eaten a big meal. Once the gas is turned off the drug leaves the body quickly and the patient will be back to normal by the time that you are ready to leave.
 - **Mouth props:** A rubber covered tool or soft block is placed in the patient's mouth to keep them from closing if they cannot keep their mouth open for the dental care. It is often called a "tooth chair" and is used so that the care is safe. This way the patient does not bite down on a tool that is hard or sharp. It is often easier for the patient to not have to think about always opening their mouth.
 - **Protective immobilization by dentist, or assistant:** The patient is kept from moving by holding the patient's hands, arms, or upper body or holding the patient's head between the dentist's arm and body.
 - **Papoose Boards:** This is a special mesh body wrap that keeps the patient from moving around and hurting themselves or dental staff during treatment. They are often referred to as a blanket and are used for the shortest period of time that is needed. Some patients' with irregular body movements due to muscle control disorders may also need this body wrap to protect them during treatment. After using the wrap, red marks may be present on the skin around the wrists because of the cloth that helps hold the hands. For most patients', these marks will go away within a short time. In addition the patient who is in a wrap may get warm and sweaty. This wrap is never used to punish the patient for their behavior but only to protect both the patient and dental staff. The patient will not be placed in the body wrap without consent.
 - **Oral Sedative Pre-Appointment Medication:** Drugs can be used to calm and relax the patient who is unable to understand or cooperate for the dental treatment. These drugs may be prescribed by the dentist or by the patient's primary care physician.
4. There are possible benefits of agreeing to this plan for the patient and these have been explained to me.
 5. I may have other choices including no treatment for the patient. I understand the risks of those choices.



6. All records including x-rays, photos (including full face), recordings and drawings will remain the sole property of The Nisonger Dental Program. These records may be used for teaching and publication.
7. There is no guarantee of treatment results.
8. It is my responsibility to follow the post-treatment protocols of The Nisonger Dental Program.

I the patient, or my Legal Guardian is, signing this consent. The opportunity to ask questions about these risks was given. All questions were answered. I, or the legal guardian, understand and give consent for treatment for the patient.

Print Patient Name

(Signed by court appointed guardian if patient is not their own)



Research Registry

FOR COMPLETION BY CLIENTS THEMSELVES OR LEGALLY AUTHORIZED REPRESENTATIVES (I.E., PARENTS OR GUARDIANS)

Clients Name: _____

One mission of the Nisonger Center is to conduct research. It helps us answer important questions and learn how to improve our services. It also helps us provide personalized care to improve people's lives.

Sometime in the future, we may do a study that is relevant to you or your family. You or your child may want to participate in the study. May we contact you and give you chance to do that?

Even if you say "Yes" on this form, you can still say "No" to participate in a study. You can ask us to remove this permission at any time.

Even if you say "No" on this form, you can still have access to all services at Nisonger Center and OSU Medical Center.

- ☐ Yes, you may contact me
☐ No, I would prefer not to be contacted. (If NO, please initial to the right and stop here) _____

If YES, please supply the following information:

Today's date: ____/____/____
mm dd yyyy

Clients date of birth: ____/____/____
mm dd yyyy

Gender ☐ Male ☐ Female

Does this person have diagnoses, such as the following? (Please check all that apply):

- ☐ Autism Spectrum Disorder (sometimes called Autism, Asperger's Syndrome, Pervasive Developmental Disorder)
☐ Intellectual Disability
☐ Developmental Delay
☐ Other (Please list): _____

Preferred Phone Number: _____

Home Address: _____

Secondary Phone Number: _____

City: _____

Email: _____

State: _____ Zip: _____

Signature: _____

Print Name: _____

Relationship to Client: ☐ Myself
☐ Parent
☐ Other: _____
(i.e., Legal Guardian)

Thank you for your time!

**Should you ever wish to have this information removed from our files, please contact Tamara Hager at (614) 685-3196 or at Tamara.Hager@osumc.edu