THE OHIO STATE UNIVERSITY
NISONGER CENTER

Dental Program

345 McCampbell Hall, 3rdFL
1581 Dodd Drive
Columbus, OH 43210
Phone: 614-685-3197
Fax: 614-685-3212
Email: NisongerDental@osumc.edu
nisonger.osu.edu

Please complete and return all completed forms.

Forms can be returned via email, mail, or fax

In continuation of providing the highest quality care for our patients, the Nisonger Center Dental Program requires updated forms prior to 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 1
2. Patient Insurance and Financial Responsibility Agreement; page 2
3. Medical Health History Form; page 3
4. Medication List; page 4
5. Pre-Visit Questionnaire; page 5-7
6. Treatment Consent Form; page 8
7. HIPPA Form; page 9
8. Broken Appointment Policy; page 10
9. Behavior Management Consent; pages 11-12
10. Insurance Card
11. Guardianship Documentation - from Probate Court if a patient is not their own guardian

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PATIENT REGISTRATION

First Name:_____Last Name:_____MI:_____
Date of Birth: _____ SSN:_____
Address:_____
City, State, Zip: _____
Live in a Care-Facility? ☐Yes ☐No If yes, Facility Name: _____
Home Phone:_____ Cell Phone:_____
Alternate Phone: _____ Primary Contact #: ☐Home ☐Cell ☐Alternate
E-Mail Address: _____
Gender: ☐Male ☐Female ☐Other _____ Pronouns: ☐He/Him ☐She/Her ☐They/Them
Marital Status: ☐Married ☐Single ☐Other _____
Ethnicity: ☐Caucasian ☐African American ☐Asian ☐Hispanic ☐American Indian
☐Native Hawaiian ☐Prefer not to answer ☐Other_____

Is the patient their own legal guardian? ☐Yes ☐No
Full Legal Guardian Name: _____ Phone: _____
Email: _____
Please supply proof of legal guardianship with court documentation

Does the patient receive services from the County Board of Developmental Disabilities?
☐Yes ☐No If yes, what county?_____

Is the patient the responsible party? ☐Yes ☐No
Responsible Party:_____ Phone:_____
Relationship to patient: ☐Guardian ☐Self ☐Other_____
Address: _____
Responsible Party DOB:_____SSN: _____

Emergency Contact:_____Phone:_____
Relationship to Contact: ☐Guardian ☐Parent ☐Other_____

PRIMARY INSURANCE Please provide a copy of Insurance Card(s)
Subscriber Name: _____ Subscriber DOB: _____
Subscriber SSN: _____ Relationship to Patient: _____
Subscriber Employer Name: _____
Insurance Company:_____ Insurance ID#: _____
Insurance Company Phone#: _____
Insurance Company Claims Address: _____

SECONDARY INSURANCE
Subscriber Name: _____ Subscriber DOB: _____
Subscriber SSN: _____ Relationship to Patient: _____
Subscriber Employer Name: _____
Insurance Company: _____ Insurance ID#_____
Insurance Company Phone#: _____
Insurance Company Claims Address: _____

Guardian Signature: _____ Date: _____
(Signature of court appointed guardian if patient is not their own)

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PATIENT INSURANCE VERIFICATION AND FINANCIAL RESPONSIBILITY AGREEMENT

Financial Responsibility

It is understood that _____(name of responsible individual) is directly responsible for all payments and financial obligations for any services that the patient receives at the Nisonger Dental Program.

It is understood that payment in full is expected at time of the patients appointment if patient does not have a dental insurance carrier that the Nisonger Dental Program is currently contracted with. It is understood that **the above referenced individual** is responsible for paying estimated co-pays, deductibles, and co-insurance payments at the time of appointment for insurance carriers that are currently contracted with the Nisonger Dental Program.

It is understood that if the patient comes to the Nisonger Dental Program on the day of the appointment without one of the acceptable forms of payment listed below, the Nisonger Dental Program has the right to reschedule the appointment.

Insurance Verification and Assignment

I certify that the information provided about the patients active dental and/or medical insurance coverage is correct to the best of my knowledge.

I authorize the release of any dental/medical records or other information including the diagnosis and treatment rendered to the patient as requested by my dental and/or medical insurance carrier.

I authorize the assignment of benefit payment(s) from the patients insurance carrier(s) directly to the Nisonger Dental Program and to the practitioner who provided service(s) to the patient.

Patients who have dental and/or medical insurance benefits:

It is understood that the Nisonger Dental Program will attempt to gain as many benefits as possible from the patients insurance carrier(s) for the services provided to the patient. It is understood that there is no promise or guarantee of payment or coverage from the patients insurance carrier(s) for the services provided to the patient. It is understood that it is **the above referenced individuals** responsibility to pay any balance due after insurance processing, and/or insurance payment. This payment must be made in the full amount within 30 days.

Payment Options

Accepted methods of payment: Cash, Check (established patients only), Visa or MasterCard

MEDICAID PATIENTS: It is understood that patient must present their current Medicaid identification card at the time of each appointment. It is also understood that after Medicaid has processed the claim, there may be a portion of the bill remaining. It is understood that any remaining balance will be **the above referenced individuals** financial responsibility and agree to pay this remaining balance within 30 days.

MEDICARE PATIENTS: It is understood that the Nisonger Dental Program is **NOT** a Medicare Contracted Provider. It is understood that this means services completed at the Nisonger Dental Program **CANNOT** be submitted for payment to Medicare. It is understood that **the above referenced individual** is responsible for any and all fees charged to the patient during their appointment for the services they received and that payment is due at the time of the appointment.

Patient Name

(Signature of the financially responsible individual)

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Patient Medical Health History

Patient Name: _____ Date: _____

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

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

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

Currently under the care of a Physician? □Yes □ No
Physician Name / Specialty: _____
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

Guardian Signature: _____
(Signature of court appointed guardian if patient is not their own)

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MEDICATION LIST

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

Are you allergic to any medications? Reaction? _____

_____

_____

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Pre-Visit Questionnaire for Caregivers of Persons with Disabilities

The purpose of this form is to share important details about the patient's medical history, oral care routine, diet preferences, communication abilities and sensory sensitivities with the dental team. This information will help the dental team prepare to make the dental visit as comfortable as possible for the patient.

Patient Name: _____ Preferred Name: _____

ORAL CARE:

1. Please describe the patient's at-home dental routine: _____
   _____
2. Does the patient use an ☐ electronic or ☐ manual toothbrush?
3. Does the patient floss? ☐ No ☐ Yes
4. Does the patient need assistance when brushing their teeth? ☐ No ☐ Yes

ORAL CARE GOALS:

5. What are your expectations for the patient in our dental office? _____
   _____
6. What are your oral health expectations of the patient, in general?
   _____
   _____
   _____

DIET:

7. Select all that apply. How often does the patient eat during the day:
   ☐ 3 meals a day ☐ snacks in between meals ☐ eats only when hungry ☐ NG tube/TPN
8. Does the patient drink soda/energy drinks? ☐ No ☐ Yes
9. Does the patient drink fruit juice? ☐ No ☐ Yes
10. What are the patient's food preferences and dislikes?
    _____
    _____

SOCIALIZATION:

11. What does the patient do to self-regulate? _____
12. Describe how the patient interacts/reacts with peers or adults outside of home, school, or work:
    _____
13. Is the patient responsive to instructions? ☐ No ☐ Yes If yes, provide an example:
    _____
14. Do you use toys, activities, or treats to reward or encourage positive behavior? ☐ No ☐ Yes If yes, please describe what is used at home, school, or work:
    _____

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15. Does the patient have a preference of a male or female provider?

☐ No ☐ Yes If yes, which gender produces a more positive response?

_____

SENSITIVITIES:

16. If the patient is sensitive to any of the following, check the box that applies, and list any specific issues the patient is sensitive to:

☐ **Smell**: office setting, perfume, cologne or other: _____

☐ **Sounds**: Music, drill, phones, voices, clock, other: _____

☐ **Sight**: Dim lights, bright lights, overhead light, mirrors, shiny tools, other: _____

☐ **Positions**: Chair height or tilt, being "still," lying flat, other: _____

☐ **Proximity**: People, water, light, X-ray machine, other: _____

☐ **Touch**: Gloves, air, gauze, water, suction, room and water temperature, toothbrushing, other:

_____

☐ **Taste**: Gloves, toothpaste, fluoride, other: _____

☐ **Words**: Needle, Hurt, Drill, other: _____

17. How does the patient indicate/communicate his/her/their sensitivity(ies)? _____

_____

_____

18. How have you responded to the patient's sensitivity(ies)? And how has this worked?

_____

_____

COMMUNICATION:

19. Is the patient able to communicate verbally? ☐ No ☐ Yes
20. Are there certain visual or verbal cues that might help the dental team? If yes, please describe:

_____

_____

21. Are there any useful phrases or words that work best with the patient? Please describe:

_____

22. Does the patient use non-verbal communication? ☐ No ☐ Yes If yes, please explain:

_____

23. Will you be bringing a communication system with you? ☐ No ☐ Yes If yes, please explain:

_____

24. Are there any others supports that we can have available to assist with communication?

☐ No ☐ Yes If yes, please explain: _____

_____

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OTHER:

25. Does the patient have any self-injurious behaviors? ☐ No ☐ Yes If yes, please describe:

_____

_____

26. Does the patient have aggressive behaviors such as bite, scratch, hit, or kick? ☐ No ☐ Yes
Please list any specific behavior challenges the dental team may need to be aware of:

_____

_____

27. Will patient cooperate for dental treatment? ☐ No ☐ Yes

Has there been a bad dental experience? ☐ No ☐ Yes if yes, please explain:

_____

_____

28. Does the patient gag or throw up easily? ☐ No ☐ Yes

29. Has the patient had general sedation for past dental treatment? ☐ No ☐ Yes

30. Does the patient require general sedation for dental treatment? ☐ No ☐ Yes

31. Is there anything else our dental office should be aware of to help make dental visits as comfortable as possible for everyone involved? ☐ No ☐ Yes If yes, please describe:

_____

_____

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 patient/staff. It is my responsibility to inform the dental office of any changes in medical and behavioral status.

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

This form has been adapted from three sources to help dentists capture the most relevant details about patients with special health care needs: "Autism Speaks: Treating Children with Autism Spectrum Disorders: Dental Tool Kit for Families"; Center for Pediatric Dentistry: Pre-Visit Parent Questionnaire for Patients with ASD; and Dr. Clive Friedman, Pediatric Dental Specialist in London, Ontario: Dental Office Pre-visit Questionnaire for Parents and Caregivers.

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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 patient/individual legal guardian, _____(name of individual) is financially responsible for 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, the patient will be considered dismissed from Nisonger Dental Program.

☐ 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 for publications.

☐ There is no guarantee of treatment results.

☐ It is my responsibility to follow the post-treatment protocols of The Nisonger Dental Program.

☐ Emergency treatment is not complete dental care. I understand that it is my responsibility to seek continued dental care after receiving emergency treatment, as recommended.

_____ _____
Date (Signature of court appointed guardian if patient is not their own)

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

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: _____

_____
(Signature of court appointed guardian if patient is not their own)

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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 10 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.

_____
(Signature of court appointed guardian if patient is not their own)

_____
Date

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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 2-page 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. 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. Positive reinforcement is used throughout 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, assistants, 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.

    - **Mouth props:** A rubber covered tool or soft block often called a "tooth chair" is placed in the patient's mouth to keep them from closing if they cannot keep their mouth open for dental care. Mouth props help patient not bite down on a tool that is hard or sharp.

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- **Nitrous oxide/oxygen inhalation (laughing gas):** Laughing gas is a safe and effective drug to help the patient relax. 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 from the gas mask. 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 they're ready to leave.

- **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:** Medical Immobilization and Protective Stabilization (MIPS) devices are 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 needed. Some patients with irregular body movements due to muscle control disorders may also need MIPS 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:** Prescriptions can be used to calm and relax the patient who is unable to understand or cooperate for the dental treatment. These prescriptions 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.

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.

_____
(Patient Name)

_____
(Signature of court appointed guardian if patient is not their own)

_____
Date