SCHAMEL
FAMILY DENTISTRY

WELCOME TO OUR PRACTICE

Thank you for choosing us for your dental care. Because your dental needs are our top priority, we strive to stay up-to-date with current research, techniques and technologies. We believe in open and honest communication, and the enclosed information is provided to ensure a smooth transition to our practice.

During your initial appointment, you will meet with one of our doctors first for a comprehensive examination in which we will evaluate your teeth, your gums, and any dental x-rays. We will listen carefully to your dental concerns and work together to develop a treatment plan to meet your oral health goals. If our schedule allows, a dental cleaning may be completed the same day; however, a more complex medical history and/or dental needs may require a second appointment.

To assist us in providing a smooth and efficient consultation, please review and complete all included forms prior to your initial appointment. Please also bring with you a list of all current medications that you are taking. Please contact your previous provider and request your dental records and dental x-rays. They can be emailed to smile@parkwaydentalhealth.com.

PLEASE NOTE: If previous records and/or dental x-rays are not received it is our policy to update those so that our doctors can complete a thorough examination. **These x-rays may not be covered by your dental insurance if they were taken by your previous provider.** Please confirm that your previous provider has sent all of your records to us **48 hour**s prior to your dental appointment.

If you have dental insurance, please bring with you a copy of your insurance card and a photo ID.

IMPORTANT: All patients under the age of 18 are required to be accompanied by a parent/guardian.

Broken Appointment Policy: We require **48 hour notice** for all new patients who may need to cancel or reschedule an initial appointment. If you do not provide 48 hours notice, it is possible that you will not be reappointed. Established patients are required to give 24 hour notice when rescheduling or canceling appointments, or they may be charged a **$40** broken appointment fee.

If you have further questions or concerns, please email us at smile@parkwaydentalhealth.com or call us at (937) 435-9110, and we will do our best to respond within 24 hours Monday - Thursday.

Welcome again, and we look forward to meeting you!

Sincerely,

Dr. Kevin Schamel, Dr. Mary Beth Schamel and the Schamel Family Dentistry Team

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:

X_____ Today's Date:_____

Patient Name:_____ Birth Date:_____

SCHAMEL
FAMILY DENTISTRY

PATIENT INFORMATION

First Name: _____ **MI:**_____**Last Name:**_____

Preferred Name:_____ **Title:** ○ None ○ Mr. ○ Mrs. ○ Miss ○ Ms. ○ Dr.

Birth date:_____ **Social Security #:**_____**Gender:** ○ Male ○ Female

Cell #:_____ **Home #:** _____ **Work #:** _____ **Ext:**_____

Address:_____**City/State/Zip:**_____

Email:_____

How did you learn of our office?

○ Friend ○ Family ○ Website ○ Facebook ○ Google Search ○ Mail
○ Drive-by ○ Radio ○ Insurance ○ News ○ Other**:**_____

Marital Status:

○ Single ○ Married ○ Divorced ○ Widowed ○ Significant Other

Appointment Preference:

○ None ○ AM ○ PM

On Short Notice?

○ Yes ○ No

For your convenience our office can communicate with you by text or email. It's okay for the office to:

○ Text Me ○ Email Me ○ Send me appointment reminders

Patient is (select all that apply):

○ Patient ○ Policy Holder ○ Responsible Party

Employed:

○ Full-Time ○ Part-Time ○ N/A

Student:

○ Full-Time ○ Part-Time ○ N/A

In case of emergency, please contact:

Name: _____**Phone:**_____**Relation:**_____

Who is responsible for your account:

○ Self ○ Spouse ○ Father ○ Mother ○ Other

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:

X_____ Today's Date:_____

Patient Name:_____ Birth Date:_____

SCHAMEL
FAMILY DENTISTRY

INSURANCE INFORMATION

Do you have insurance: ⚪ Yes ⚪ No

Type of Insurance: ⚪ Dental ⚪ Medical

Employer:_____ **Insurance Company Name:**_____

ID #:_____ **Group #:**_____ **Group Name:**_____

Address:_____ **City/State/Zip:** _____

Policy Holder First Name:_____ **Policy Holder Last Name:**_____

Relation:_____ **Insured Birthdate:**_____ **Social Security #:**_____

Policy Holder Phone:_____

Policy Holder Address:_____ **City/State/Zip:**_____

Do you have SECONDARY insurance: ⚪ Yes ⚪ No

Type of Insurance: ⚪ Dental ⚪ Medical

Employer:_____ **Insurance Company Name:**_____

ID #:_____ **Group #:**_____ **Group Name:**_____

Address:_____ **City/State/Zip:** _____

Policy Holder First Name:_____ **Policy Holder Last Name:**_____

Relation:_____ **Insured Birthdate:**_____ **Social Security #:**_____

Phone:_____

Address:_____ **City/State/Zip:**_____

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to this dental office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:

X_____ Today's Date:_____

Patient Name:_____ Birth Date:_____

SCHAMEL
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MEDICAL HISTORY

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

DENTAL HISTORY

Do you have a specific dental problem? If yes, please list.	◯Yes ◯No	If yes_____
Do you have regular dental exams? Last visit?	◯Yes ◯No	If yes_____
Do you brush and floss on a routine basis? How often?	◯Yes ◯No	If yes_____
Have you had dental x-rays in the last 5 years? When?	◯Yes ◯No	If yes_____
Any popping, clicking, or discomfort in your jaw joint?	◯Yes ◯No	If yes_____
Have you ever had trouble following tooth removal?	◯Yes ◯No	If yes_____
Do your gums ever bleed?	◯Yes ◯No	If yes_____
Do you grind your teeth?	◯Yes ◯No	If yes_____
Do you smoke or chew tobacco products?	◯Yes ◯No	If yes_____
Have you ever thought about straightening your teeth?	◯Yes ◯No	If yes_____
Are you interested in a brighter smile?	◯Yes ◯No	If yes_____

MEDICAL HISTORY

Are you under a physician's care now? If yes, why?	◯Yes ◯No	If yes_____
Has your physician ever recommended antibiotic premedication for your dental visits?	◯Yes ◯No	If yes_____
Are you taking any medications, pills or drugs? If yes, please list.	◯Yes ◯No	If yes_____ _____ _____
Have you ever taken Fosmax, Boniva, Actonel or any other medications containing bisphosphonates?	◯Yes ◯No	If yes_____
Do you use controlled substances?	◯Yes ◯No	If yes_____

WOMEN: Are you…

◯Pregnant/Trying to get pregnant? ◯Nursing? ◯Taking oral contraceptives?

ALLERGIES

Are you allergic to any of the following?

◯Aspirin ◯Penicilin ◯Codeine ◯Acrylic
◯Metal ◯Latex ◯Sulfa Drugs ◯Local Anesthetics
◯Other:_____

Do you have or have you had, any of the following?

AIDS/HIV Positive	◯Yes ◯No	Chemotherapy	◯Yes ◯No	Drug Addiction	◯Yes ◯No	Cold Sores/Fever Blisters	◯Yes ◯No
Artificial Joint	◯Yes ◯No	Low Blood Pressure	◯Yes ◯No	Radiation	◯Yes ◯No	Hepatitis A	◯Yes ◯No
Artificial Heart Valve	◯Yes ◯No	Epilepsy or Seizers	◯Yes ◯No	Heart Attack/Failure	◯Yes ◯No	Tuberculosis	◯Yes ◯No
Irregular Heartbeat	◯Yes ◯No	Rheumatic Fever	◯Yes ◯No	Heart Trouble/Disease	◯Yes ◯No	Kidney Problems	◯Yes ◯No
Cancer	◯Yes ◯No	Heart Murmur	◯Yes ◯No	Hepatitis B or C	◯Yes ◯No	Excessive Bleeding	◯Yes ◯No
Stomach/Intestinal Disease	◯Yes ◯No	High Blood Pressure	◯Yes ◯No	Diabetes	◯Yes ◯No	Stroke	◯Yes ◯No
Heart Pacemaker	◯Yes ◯No	Asthma	◯Yes ◯No	Mitral Valve Prolapse	◯Yes ◯No	Thyroid Disease	◯Yes ◯No
Sleep Apnea	◯Yes ◯No	Arthritis	◯Yes ◯No	Herpes	◯Yes ◯No		

Have you ever had any serious illnesses not listed above? ◯Yes ◯No

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 (or patient's) health. It is my responsibility to inform Schamel Family Dentistry of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:

X_____ Date:_____

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CONSENT TO CONTACT

Please provide the following information on how you would like the office to contact you and to whom you give access to your information.

I authorize contact from Schamel Family Dentistry to confirm my appointment, treatment and billing information via:

⚪ Cell Phone ⚪ Home Phone ⚪ Work ⚪ Email ⚪ Text

Please list any other parties who can have access to your information. This includes spouse, partners, parents, step parents, grandparents, care takers and/or individuals. Information includes anything related to your appointments, treatment, billing and health.

Name: _____

Relationship: _____

Phone #: _____

Name: _____

Relationship: _____

Phone #: _____

Name: _____

Relationship: _____

Phone #: _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:

X_____ Today's Date:_____

Patient Name:_____ Birth Date:_____

SCHAMEL
FAMILY DENTISTRY

HIPAA NOTICE OF PRIVACY PRACTICES

for the Facility of:
Schamel Family Dentistry
6450 Centerville Business Parkway, Centerville, OH 45459

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 16, 2026 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they participate in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to perform their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

SUD Treatment Information. If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CRF Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us.

In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few expectations, for disclosures of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already acted in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an account of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this account more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request expect in the case where the disclosure is to the health plan for purposes of carrying out payment or health care operations, and the information pertains solely to the health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or locations, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us by using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

PRIVACY OFFICIAL NAME AND CONTACT INFORMATION:

Privacy Official Name: Dr. Kevin Schamel, DDS
Telephone: 937-435-9110 Fax: 937-435-0918
Address: 6450 Centerville Business Parkway, Centerville, OH 45459
Email: smile@parkwaydentalhealth.com

I hereby acknowledge that I have received a copy of this office's Notice of Privacy Practices. I may refuse to sign this acknowledgement. To obtain a paper copy I may request it from the office or the website at www.schameldds.com.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:

X_____ Today's Date:_____

Patient Name:_____ Birth Date:_____

SCHAMEL
FAMILY DENTISTRY

CONSENT FOR DENTAL PHOTOGRAPHY

The undersigned, do hereby authorize and consent to the use of photographs, videos and x-rays of me taken by Schamel Family Dentistry before, during, and after treatment. I grant them permission to reproduce, print and publish photographs taken of me in a professional publication or in the form of prints, film or slides in connection with articles and lectures dealing with the jaw or dental disorders. I specifically waive any claim for invasion of my personal privacy which might accrue to me on account of the use of such pictures without my express consent in each instance. I do consent to the use of my photographs or images or videos or x-rays for promotional purposes including but not limited to, advertising, website, social media, publicity, commercial or display of use, patient education, and in-office promotional education for Schamel Family Dentistry only.

I further understand that if the photographs and/or images are used, my name or similar identifying information will not be used. No full face or comparable photos will be used without your additional express written authorization. I further acknowledge that my participation is voluntary and that I will not receive any compensation, financial or otherwise, with respect to the taking, use or publication of these photographs for any dental office publications. I acknowledge and agree that publication of photographs confers no rights of ownership or royalties whatsoever.

⚪Yes ⚪ No

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:

X_____ Today's Date:_____

Patient Name:_____ Birth Date:_____

SCHAMEL
FAMILY DENTISTRY

FINANCIAL POLICY

As validated by my signature on the bottom of this form, I understand and agree that:

All patient balances are due immediately at time of service. Please ask us if you are interested in learning about third party financing offered through CareCredit, which may allow you to finance your treatment in low monthly payments.

Should a balance accrue on the account, a statement will be sent and payment is to be made, in full, by the date on the statement. If payment is not paid within 30 days, interest may be applied to the entire account balance. A revised statement with the new account balance, payable immediately, will be sent.

A returned check fee will be applied for each check payment returned to us by your bank.

Dental insurance is a contract between the patient, their employer (if applicable) and the insurance provider. Submitting claims for payment to the insurance provider is a courtesy provided by the dentist, not an obligation. Ultimately, I am responsible for any services that are unpaid by my insurance provider.

If there is dental insurance on the account, I understand that the office will provide a pre authorization estimate based on the dental information I have provided. Final payment is subject to the terms and conditions of my insurance provider on the date of service. As such, until payment is received from my insurance provider, no patient payment is final.

PLEASE NOTE: WE ARE NO LONGER A PARTICIPATING PROVIDER FOR ANY MEDICARE ADVANTAGE PLANS. You may still use Medicare plans at our office. Please check with your plan to assure that you have Out of Network Benefits. By signing this agreement you understand that you will be balance billed for anything that your plan does not allow.

WE ARE NOT A PROVIDER FOR ANY STATE FUNDED DENTAL PLANS AND ARE UNABLE TO BILL TO THEM.

Estimates and treatment plans are based upon information gained from the examination. As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. This is a preliminary estimate only and lab charges (if applicable) have been estimated and included in the total.

Estimates do not take into consideration any money that was billed toward my financial maximum or frequency limits that may have been used at other dental offices.

A submission to my insurance provider will be sent to determine an approximate final investment. However, it is an estimate only. Final insurance splits may be adjusted upon receiving the predeterminations. Predeterminations from my insurance provider(s) are NOT a guarantee of payment.

As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. The office will make an effort to anticipate any changes in the treatment plan and advise me at that time. However, such events are unpredictable. Likewise, the timing or spacing of appointments may need to be modified as needed to accomplish the best result possible.

I have read, understand and agree to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all fees for services rendered to me and/or my family.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:

X_____ Today's Date:_____

Patient Name:_____ Birth Date:_____

SCHAMEL
FAMILY DENTISTRY

APPOINTMENT POLICY

Our goal is to provide high quality care to our patients and respect their schedule. In fairness to other patients, and the office staff, we require advanced notice when rescheduling or cancelling an appointment.

When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to cancel or reschedule your appointment, established patients are required to give us **at least 24 hours** notice. We require new patients to give us **at least 48 hours** notice before their first appointment.

We understand that conflicts arise; however failing your appointment or canceling without adequate notice more than once may result in a **$40** broken appointment fee.

Patients who continue to no-show and/or cancel without notice may be dismissed from the practice and asked to find another dentist.

Any patient who is late may be considered a “no show” for their appointment and may need to be rescheduled.

I have read, understood and agree to the above appointment policy.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:

X_____ Today’s Date:_____

Patient Name:_____ Birth Date:_____