Patient Information

(Please Print)

Legal Name: _____ Preferred Name (If different): _____ Male __ Female __
(Last) (First) (MI)

Marital Status: ____ Birth Date: _____ SS#: _____ Drivers License #: _____

Home Address: _____
(Street) (Apt#) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____ Ext: ____ Cell: _____

Email Address: _____ Whom may we thank for referring you? _____

Responsible Party Information

Name: _____ Relationship: _____ Marital Status: ___
(Last) (First) (MI)

SS#: _____ Birth Date: _____ Drivers License #: _____ Male __ Female __

Home Address: _____
(Street) (Apt#) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____ Ext: ____ Cell: _____

Employment Information

Employer Name: _____ Occupation: _____ Do you have Insurance? _____

Employer Address: _____
(Street) (Suite#) (City) (State) (Zip)

Primary Insurance Information

Name of Insured: _____ Relationship: _____ Date of Birth: _____
(Last) (First) (MI)

SS#: _____ ID#: _____ Group #: _____ Male __ Female __

Insured Address: _____
(Street) (Apt#) (City) (State) (Zip)

Insurance Plan Name and Address and Phone:

_____

_____

_____

Do you have Secondary Coverage? _____, if so, we will give you the necessary information to assist you in filing for secondary coverage.

Emergency Information

In the case of an emergency, who may we contact? _____ Phone #_____

I affirm the information I have given is correct to the best of my knowledge. I understand this information will be held in the strictest confidence and cannot be released to anyone without my consent. It is my responsibility, as the patient, to notify the office of any changes to my medical status. I authorized Dr. Michael Burwell and his Clinical Auxiliary to perform the necessary dental services to determine my dental and periodontal needs.

Signature (Patient/Parent or Guardian of Minor): _____ Date: _____

Office Policies and Payment Conditions

Payment is due at the time of service. We accept cash, checks, and major credit cards. We offer an outside financing option known as Care Credit. A Payment Plan may be utilized in accordance with Office Policies.

Insurance

This office will prepare insurance claims and assist in collecting from your insurance company. All money paid to the office will be credited to the patients account. In the event of an insurance over-payment or the insurance requests to be refunded,we will refund the insurance company. In the event your insurance does requests a refund, the patients account will be charged. This office cannot render services under the assumption that our charges will be paid by an insurance company. Patients who carry dental insurance must understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for all charges incurred, even in the event the procedure or procedures are deemed by your insurance as a non-covered procedure. This office and its Clinical Team follow the "Standard of Care" set by the State Board of Dental Examiners to assure you the best care possible. At the time of service, our office will estimate your portion based on benefit information given prior to your visit. You will be expected to pay the estimated portion at the time services are rendered. This portion is only an estimate. A statement will be sent every month to keep you aware of your account. After 90 days, you will be responsible for any remaining balance.

Office Policies

All emergency dental services, or any dental services performed without previous financial arrangements must be paid in cash at time of services.

We respect your concern for your loved ones but due to the delicacy of our equipment and other patient privacies we request only the patient be present in the operatory. Additional family members must wait in our reception area.

We value your time and hope you will value ours. Our office reserves the right to charge $25.00 for broken appointments without a 24 hour notice.

Authorizations

I do hereby authorize Columbus Family Dental or Dr. Michael Burwell to release all information necessary to secure the payment of benefits. I authorize the use of this signature on file for all insurance claim submission whether manual or electronic.

I do hereby authorize dental services for my child including, but not limited to, X-rays, treatment and administration of anesthetics deemed necessary or advisable by the Doctor, whether or not I am present at the appointment when treatment is rendered (if applicable, please initial _____,

I have read the above office policies and payment conditions and agree to their content. My signature below represents my agreement.

Signature: _____ Date: _____
(Signature of patient, parent/guardian)

Patient Health Information **Patient Name:** _____

Are you currently under the care of a Physician? Please explain.

Physicians Name: _____ Phone Number: _____

Is there anything about your SMILE you would like to change? _____

___ Do you have or had any of the following? (Please Circle)

HIV	Allergies (List) _____
Asthma	Blood Disease
Cancer (Specify_____)	Diabetes
Dizziness	Epilepsy
Excessive Bleeding	Fainting
Glaucoma	Growths
Hay Fever	Head Injuries
Heart Disease	Heart Murmur
Hepatitis (Specify _____)	High Blood Pressure
Jaundice	Kidney/Liver Disease
Mental Disorders	Nervous Disorders
Pacemaker	Pregnancy (Due Date _____)
Radiation Treatment	Respiratory Problems
Rheumatic Fever	Rheumatism
Sinus Problems	Stomach Problems
Stroke	Tuberculosis
Tumors	Ulcers
STD (Specify	Other _____

Are you allergic to any of the following: (Please circle)

Aspirin	Penicillin
Codeine	Latex
Other drugs allergies : _____	

Are you taking any of the following:

Aspirin	Insulin/Diabetic Drugs
Blood Thinners	Tranquilizers
Recreational Drugs	Steroids

Please List any prescription drugs you are currently taking: _____

Have you ever had any complications following dental treatment? (Y) (N) If yes, explain _____
Do you have a Joint Replacement or Heart Valve Replacement? (Y) (N)
Are you currently in dental pain? (Y) (N)
Do you need an Antibiotic Premedication before dental work? (Y) (N)
Do your gums bleed? (Y) (N)
Do you smoke cigarettes? (Y) (N) Use any other Tobacco Products (Y) (N) Explain _____
Have you been admitted to the hospital or needed emergency care in the past 2 years? Explain _____
WOMEN ONLY: Are you taking Birth Control? (Y) (N) Type? _____ Could you be Pregnant? (Y) (N) (Unsure)

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform Dr. Michael Burwell and his Clinical Team at the next appointment without fail.

Signature: _____ Date: _____
(Signature of Patient or Guardian)

Printed Name: _____

Notice of Privacy Practices (HIPAA)

I understand I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
Obtaining payment from third party payers (i.e.my insurance company);
The day-to-day healthcare operations of the office.

I have been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to date I revoke that consent is not affected.

Date: _____

Printed Patient Name: _____

Relationship to Patient: _____

Signature: _____

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