Patient Information

(Please Print)

Legal Name: _____ Preferred Name (If different): _____Male__ Female__
(Last) (First) (MI)

Marital Status: ____ Birth Date: _____ SS#: _____ Driver's 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: _____ Driver's 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) (Suite #) (City) (State) (Zip)

Insurance Plan Name: _____ Address: _____ 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 D. 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: _____

Patients 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 drug allergies: _____

Are you taking any of the following: (Please Circle)

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: _____

Columbus Family Dental Office and Payment Policies

Thank you for choosing Columbus Family Dental for your dental needs. Your dental needs as well as your financial needs are important to us. We feel a clear understanding of our office policy and payment policy is important to our professional relationship.

Insurance

As a courtesy to our patients we will gladly process your insurance claim. We participate in many insurance plans, but please inquire if we accept yours. It is the responsibility of the patient to inform our office of any changes with insurance policies. We will ESTIMATE your patient portion and that amount will be due at the time of service. Patients who carry dental insurance are responsible for all charges incurred, even in the event the procedure or procedures are deemed by your insurance as a non-covered procudure. Columbus Family Dental follows the "Standard of Care" set by the board of Dental Examiners to assure you the best care possible. After 90 days, you will be responsible for any remaining balance.

Initial _____

Payment Options

Plan A: A Cash payment in full on the day of each visit. To demonstrate our appreciation for patients, who are prompt with full payment, we will extend a 5% discount of the total fee.

Plan B: You may use your credit card to make a payment. We gladly accept Visa, MasterCard, or Discover as well as Health savings cards. We can accept payments over the phone or stop by and see us to make a payment.

Plan C: Payments can be made in installments for patients who qualify. You can begin your treatment with an initial down payment of only 50%. The remaining balance is due at the end of treatment. Please give us a call to set up your payment amounts.

Plan D: Long term financing is available through Care Credit for patients that qualify. Care Credit specializes in financing dental care. We offer 0% financing for 6 months through Care Credit for purchases over $250.00.

Administrative Fees

Returned checks are subject to a $30.00 fee.

If payments are not made by the due date our office reserves the right to charge a $10 late fee.

If collections and/or legal services are required to obtain payment, the patient is responsible for all legal fees and costs incurred.

Initial _____

Missed/Canceled Appointments

Once an appointment has been made, please remember that this time has been reserved for you. A **24-hour** notice is required for cancellations of appointments. Appointments which are canceled with less than 24 hours notification will be subject to a **$75** cancellation fee.

Patients who do not show up for their appointment without a call to cancel an appointment will be considered as a **NO SHOW.** Patients who NO SHOW 2 or more times in a 12-month period may be dismissed from the practice thus they will be denied any future appointments. Patients will also be subject to a **$75** no show fee.

Initial _____

Office Policy

We respect your concern for your loved ones but due to the delicacy of our equipment and other patient's privacy we request only the patient be present in the operatory. Additional family members must wait in our reception area. Minors in the lobby must be accompanied by an adult.

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 submissions 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/guardian)

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 (HIPAA). 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. 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: _____