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 Dr. Mark Griffiths 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: _____

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. Mark Griffiths 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: _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ chlorhexidine (CHX)		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ nuts _____		
☐ fruit _____		
☐ other _____		
3. heart problems, or cardiac stent within the last six months ___	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis ___	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox ___	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ___	☐	☐
27. arthritis _____	☐	☐
28. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment _____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches _____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco ___	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6)

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]_____ ☐ ☐
2. Have you had an unfavorable dental experience?_____ ☐ ☐
3. Have you ever had complications from past dental treatment?_____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?_____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?_____ ☐ ☐
6. Have you had any teeth removed or missing teeth that never developed or lost teeth due to injury or facial trauma?_____ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
11. Have you ever experienced gum recession? _____ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years?_____ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?_____ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?_____ ☐ ☐
20. Do you frequently get food caught between any teeth?_____ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your back teeth together?_____ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ ☐
24. In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed?_____ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? _____ ☐ ☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?__ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?_____ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
30. Do you clench or grind your teeth together in the daytime or make them sore?_____ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?___ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?_____ ☐ ☐
34. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____