## 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: _____ How did you hear about our office? _____

## 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 authorize Columbus Family Dental 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 procedure. Should your insurance company pay you directly for services received, you agree to assign your insurance benefits to Columbus Family Dental. 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 come into the office to make a payment.

Plan C: 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.

Plan D: For dental treatment involving the use of a dental lab, treatment can begin with a 50% down payment and then the remaining balance is due when treatment is completed.

## 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 per past due statement. Account balances 90 days or more past due will be turned over to a collection agency.

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 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 do hereby authorize Columbus Family Dental to provide communications through phone, text, or email.

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

Signature (Patient/Guardian): _____ Date: _____

# 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)**